MARKET CONDUCT EXAMINATION REPORT

AS OF DECEMBER 31, 2003

Fortis Insurance Company
501 West Michigan Street
Milwaukee, WI 53201

NAIC Group Code 019
NAIC Company Code 69477

EXAMINATION PERFORMED BY INDEPENDENT CONTRACTORS FOR

COLORADO DEPARTMENT OF REGULATORY AGENCIES
DIVISION OF INSURANCE

Fortis Insurance Company
501 West Michigan Street
Milwaukee, WI 53201

MARKET CONDUCT EXAMINATION REPORT as of December 31, 2003

Examination Performed by

Sarah S. Malloy, CIE, AIRC, PAHM, HIA, LTCP
Lynn L. Zukus, AIE, FLMI

Independent Contract Examiners

February 18, 2005

The Honorable Doug Dean
Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner:

This limited market conduct examination of Fortis Insurance Company was conducted pursuant to Sections 10-1-203, 10-1-204, 10-1-205(8), 10-3-1106, and 10-16-216, Colorado Revised Statutes, which authorizes the Insurance Commissioner to examine Individual Health Insurance. We examined the Company's records at its office located at 501 West Michigan Street, Milwaukee, WI, 53201. The market conduct examination covered the period from January 1, 2003 through December 31, 2003.

The results of the examination are respectfully submitted by the following independent market conduct examiners.

Sarah S. Malloy, CIE, AIRC, PAHM, HIA, LTCP

Lynn L. Zukus, AIE, FLMI

MARKET CONDUCT
EXAMINATION REPORT
OF
FORTIS INSURANCE COMPANY

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COMPANY PROFILE

The Company first organized in LaCrosse, Wisconsin in 1892 as the LaCrosse Mutual Aid Association. The Company then moved to Milwaukee in 1900 and by 1905 took the name Time Indemnity. On February 11, 1910, the Company incorporated and changed its name to Time Insurance Company and commenced business under that name on March 6, 1910.

In April 1969, Time Holdings, Inc. was formed to become the parent company of Time Insurance Company. During January 1978, control of Time Holdings, Inc. was acquired by N.V. AMEV, a Dutch financial services company located in Utrecht, The Netherlands. During 1992, N.V. AMEV became Fortis AMEV. Effective April 1, 1998 Time Insurance Company changed its name to Fortis Insurance Company. Fortis Insurance Company's direct parent is Interfinancial, Inc., which in turn, is controlled by Fortis, Inc., in New York, New York. The ultimate controlling entities are Fortis AG, located in Belgium, and Fortis AMEV. Effective January 1, 1999, Fortis AG was renamed Fortis (B) and Fortis AMEV was renamed Fortis (NL). Since that time, Fortis (B) has been replaced by Fortis SA/NV and is a Belgian company. Fortis (NL) N.V. has been replaced by Fortis N.V. and is a Netherlands Company. The U.S. operations were known as Fortis, Inc., which was renamed Assurant, Inc., when it became a publicly traded company on the New York Stock Exchange through an Initial Public Offering (IPO) on February 5, 2004.

Fortis Insurance Company (the "Company") is a wholly owned subsidiary of Interfinancial Inc. and operates as part of the Assurant, Inc. group of life/health insurers. The Company is licensed in all states except Hawaii and New York and is also licensed in the District of Columbia.

The Company's health insurance products are principally marketed through an extensive network of independent agents by its distributors. They also market their products to individuals through a variety of exclusive and non-exclusive national account relationships and direct distribution channels. Since 2000, the Company has had an exclusive national marketing agreement with State Farm Mutual Insurance Company of Bloomington, IL. The Company also has exclusive distribution relationships with United Services Automobile Association (USAA) to market its individual health products. Short-term medical insurance and student health coverage plans are also sold through the Internet by the Company and numerous direct writing agents.

Substantially all of the individual health insurance products the Company sells are PPO plans, which offer the member the ability to select any health care provider, with benefits reimbursed at a higher level when care is received from a participating network provider. Beginning in January 2004, the Company began offering HSA products to individuals.

The Company's Colorado Certificate of Authority was issued September 24, 1956. The Company did not have business in the small employer group market in Colorado during 2003, the period of the examination.

The Company's 2003 direct written premium for accident and health plans in Colorado was $60,031,000 representing 2.52 % of the market share.

PURPOSE AND SCOPE OF EXAMINATION

Independent examiners, contracting with the Colorado Division of Insurance (DOI), in accordance with Sections 10-1-202, 10-1-203, 10-1-204, C.R.S., which empowers the Commissioner to require any company, entity, or new applicant to be examined, reviewed certain business practices of Fortis Insurance Company. The findings in this report, including all work products developed in producing it, are the sole property of the Colorado Division of Insurance.

The purpose of the limited examination was to determine the Company's compliance with Colorado insurance law and with generally accepted operating principles related to individual sickness and accident insurance. Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record. The preceding statements are not intended to limit or restrict the distribution of this report.

Examiners conducted the limited examination in accordance with procedures developed by the Colorado Division of Insurance, based on model procedures developed by the National Association of Insurance Commissioners. They relied primarily on records and materials maintained by the Company. The market conduct examination covered the period from January 1, 2003 through December 31, 2003.

The limited examination included review of the following:

Company Operations/Management
Policy Forms
Rating
Applications
Cancellations/Non-Renewals/Declinations
Claims
Utilization Review

The final exam report is a report written by exception. References to additional practices, procedures, or files that did not contain improprieties were omitted. Based on review of these areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies. The comment forms contain a section that permits the Company to submit a written response to the examiners' comments.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero ($0) tolerance level was applied in order to identify possible system errors. Additionally a zero ($0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's established policies, procedures, rules and/or guidelines.

For the period under examination, the examiners included statutory citations and regulatory references related to individual insurance laws. Examination findings may result in administrative action by the Division of Insurance. Examiners may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any insurance company or insurance product.

EXAMINERS' METHODOLOGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws and Colorado regulations. For this examination, special emphasis was given to the laws and regulations as shown in Exhibit 1.

Exhibit 1

Law/Regulation	Concerning
Section 10-1-101-10-1-130	General Provisions
Section 10-3-1104	Unfair methods of competition and unfair or deceptive acts or practices
Section 10-7-109	Suicide no defense for nonpayment
Section 10-8-513	Eligibility for coverage under the program
Section 10-8-521	Notice to residents
Section 10-8-601.5	Applicability and Scope
Section 10-8-602	Definitions
Section 10-16-101-10-16-121	Colorado Health Care Coverage Act: Part I: Short Title - Definitions - General Provisions
Section 10-16-123	Telemedicine
Section 10-16-201-10-16-219	Sickness and Accident Insurance
Section 10-16-701-10-16-708	Consumer Protection Standards Act for the Operation of Managed Care Plans
Section 10-20-102	Legislative declaration
Section 10-20-103	Definitions
Amended Regulation 1-1-6	Concerning the Elements of Certification for Accident and Health Forms, Automobile Private Passenger Forms, and Claims-Made Liability Forms
Repealed and Repromulgated Regulation 1-1-7	Market Conduct Record Retention
Repromulgated Regulation 4-2-1	Replacement Of Accident And Sickness Insurance
Regulation 4-2-5	Hospital Definition
Amended Regulation 4-2-6	Concerning The Definition Of The Term "Complications Of Pregnancy"
Amended Regulation 4-2-8	Concerning Required Health Insurance Benefits for Home Health Services and Hospice Care
Amended Regulation 4-2-11	Rate Filing and Annual Report Submissions Health Insurance

Regulation 4-2-15	Required Provisions in Carrier Contracts With Providers and Intermediaries Negotiating on Behalf of Providers
Regulation 4-2-16	Women's Access to Obstetricians and Gynecologists under Managed Care Plans
Amended Regulation 4-2-17	Prompt Investigation of Health Plan Claims Involving Utilization Review
Amended Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-existing Conditions
Amended Regulation 4-2-19	Concerning Individual Health Benefit Plans Issued To Self-Employed Business Groups Of One
Amended Regulation 4-2-20	Concerning The Colorado Comprehensive Health Benefit Plan Description Form
New Regulation 4-2-21	External Review of Benefit Denials of Health Coverage Plans
Amended Regulation 4-6-3	Concerning CoverColorado Standardized Notice Form And Eligibility Requirements
Amended Regulation 4-6-5	Implementation of Basic and Standard Health Benefit Plans
Regulation 4-6-9	Conversion Coverage
Amended Regulation 5-2-3	Auto Accident Reparations Act (No-Fault) Rules and Regulations
New Regulation 1-1-8	Penalties And Timelines Concerning Division Inquiries And Document Requests

Company Operations/Management

The examiners reviewed Company management and administrative controls, the Certificate of Authority, record retention, and timely cooperation with the examination process.

Policy Forms

The examiners reviewed the following Policy Forms, Application, Endorsements and Rider Forms.

FORM NUMBER	FORM NAME
236	Preferred 2000, Physician/Hospital PPO
Rider 2960	Copayment Rider
Rider B060-CO	Policy/Certificate Amendment Rider
Rider 2843	Mental Illness And Substance Abuse Rider
Rider 2844	Accident Medical Expense Rider
Rider 2846	Covered Prescription Drug Services/MSA Rider
Rider 2847	Traditional Coverage Rider
Rider 2849	Network Doctor/Hospital Coverage Rider
Rider 2855	Network Doctor's Office Copayment Rider
Rider B061	Network Doctor's Office Copayment Rider

Rider B098	Policy Amendment Rider
Rider 2961	Optional Term Life Rider
27016 (Rev. 1/2000)	Colorado Application For Medical Insurance
27931 (3/2003)	Colorado Application For Medical Insurance
27948-CO	Individual Medical Electronic Application

The most frequently sold individual plan in Colorado in 2003 was the Preferred 2000, Physician/Hospital PPO, Form No. 236.

Rating

The examiners reviewed a randomly selected sample of the rates charged in the sample of files used in the Underwriting-Application section of the examination. These rates were reviewed for compliance with the rate filings submitted to the Colorado Division of Insurance as the rates being used during the examination period.

Applications

For cases that were initially effective or renewed during the period from January 1, 2003 through December 31, 2003, the examiners used ACL™ software to randomly select 100 individual new business application files and fifty (50) renewal business files. The Company originally furnished a population of 2,221 renewal business files and the sample of fifty (50) was selected from this population. Twenty-four (24) of these selected files did not renew in 2003 and substitute files were provided. The Company ran a corrected report that revealed the true population to be 10,496 files that renewed in 2003. In the interest of expediting the examination a decision was made by the examiner to use the files already selected as the sample. These files were reviewed for compliance with Colorado insurance law.

Cancellations/Non-Renewals/Declinations/Rescissions

For individual cases that terminated (cancelled, non-renewed, rescinded or declined) during the period under examination, the examiners used ACL™ software to randomly select a sample of fifty (50) cancelled/non-renewed files and fifty (50) declined files. The population of thirty-eight (38) rescinded files was used as the sample. These files were reviewed to determine if the procedures used for cancellations, non-renewals, declinations and rescissions were in compliance with Colorado insurance law and contractual obligations.

Claims

The examiners used ACL™ software to randomly select samples of electronically received and non-electronically received individual claims that were reviewed for timeliness of processing only. Additionally, any claims absent fraud that were not paid, denied or settled within ninety (90) days of receipt were identified. Valid exceptions in all of these categories were included in one issue.

The examiners used ACL™ software to randomly select samples of 100 Paid claims and 100 Denied claims that were reviewed for the Company's overall claims handling practices.

Utilization Review

The Company began conducting its own Utilization Review as of September, 1999 and uses its Health Management Services Department for this purpose. The examiners used ACL™ software to randomly select a sample of fifty (50) files from the population of 795 cases of all utilization review conducted in 2003. Populations of thirty-three (33) First Level Review Appeals and thirteen (13) Second Level Review Appeals were provided. These populations were used as the sample. The files were reviewed for compliance with Colorado insurance law, and in addition the examiners reviewed the Company's utilization management procedures and policies.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of forty-four (44) findings in which the Company did not appear to be in compliance with Colorado Statutes and Regulations. The following is a summary of the examiners' findings and recommendations.

- **Company Operations/Management:** The examiners found three (3) areas of concern in their review of company operations and management. The following issues were identified:

    1. Failure to maintain some records necessary for a market conduct examination.

    2. Failure to submit an Annual Report and Certification of Forms in use or available for use in 2003.

    3. Failure to comply with all applicable requirements of the Consumer Protection Standards Act For The Operation of Managed Care Plans, including maintaining an access for each managed care network offered in Colorado.

    It is recommended that the Company review and revised its procedures to ensure that all records required for market conduct purposes be maintained, and that the Annual Report and Certification of Forms is submitted as required by Colorado insurance law. Additionally, it is recommended that the Company comply with all applicable managed care plan provisions of Colorado insurance law.

- **Policy Forms:** The examiners found twenty-four (24) areas of concern in their review of the most frequently sold individual policy forms in use during the year under examination. The following issues were identified:

    1. Failure to reflect that repairs and replacements of prosthetic devices, unless due to misuse or loss, are to be covered.

    2. Failure to disclose the existence and availability of an access plan.

    3. Failure to disclose the mandated hospitalization and general anesthesia benefit for dental procedures for dependent children.

    4. Failure to provide benefits for covered services based on a licensed provider's status, e.g., a family member or a legal guardian.

    5. Failure to allow for services appropriately provided through telemedicine.

    6. Failure to reflect a correct and complete description of coverage to be provided for prostate cancer screenings.

7. Failure to reflect correct or complete benefits to be provided for mammography screening.

8. Failure to include notification of the availability of and a description of the independent external review procedures in or attached to the policy.

9. Failure to reflect only allowable exclusions for payment of life insurance benefits.

10. Failure to allow benefits for accidental death to be paid when death results from suicide, attempted suicide or intentionally self-inflicted injury while insane.

11. Failure to reflect an accurate description of the mandated therapies for congenital defects and birth abnormalities for children.

12. Failure to reflect all required information in applications concerning replacement of coverage.

13. Failure to reflect a correct or complete definition of a dependent.

14. Failure to reflect correct or complete child health supervision service benefits to be provided.

15. Failure to reflect correct or complete disclosure information and determination questions on forms used for Business Groups of One purchasing individual coverage.

16. Failure to reflect correct and complete coverage to be provided for home health services and hospice care.

17. Failure to reflect the coverage to be provided for inherited enzymatic disorders.

18. Failure to reflect a correct or complete definition of what qualifies as creditable coverage for purposes of reducing preexisting condition limitations.

19. Failure to reflect correct and complete provisions required in individual policies.

20. Failure to reflect correct or complete elements in the CoverColorado Notice Form.

21. Failure to reflect that forty-eight (48) or ninety-six (96) hours hospital stay coverage is to be provided for newborns.

22. Failure to reflect correct information concerning allowable reasons for termination of coverage.

23. Failure to maintain and provide the Standard Health Benefit Plan Description Form to Business Groups of One applying for an individual plan.

24. Failure to include all required information in Certificates of Creditable Coverage.

    It is recommended that the Company review and revise all applicable policy forms to ensure compliance with all requirements of Colorado insurance law.

- **Applications:** The examiners found two (2) areas of concern in their review of application files for the examination period. The following issues were identified:

    1. Failure to automatically provide Colorado Health Plan Description Forms during the application process.

    2. Failure to issue CoverColorado Notices in all required instances.

    It is recommended that the Company establish procedures to ensure that Health Plan Description Forms are automatically provided during the application process and that CoverColorado notices are issued in all required instances.

- **Cancellations/Non-Renewals/Declinations:** The examiners found three (3) areas of concern during the review of the cancellation/non-renewal/declination files. The following issues were identified:

    1. Failure, in some cases, to issue Certificates of Creditable Coverage.

    2. Failure to provide written notice of eligibility for coverage under CoverColorado in all required instances.

    3. Failure to affirm or deny coverage within a reasonable time resulting in unreasonable delays in rescinding coverage.

    It is recommended that the Company establish procedures to ensure that Certificates of Creditable Coverage and CoverColorado letters are issued in all cases. Procedures should also be established to ensure that any discriminatory or unfair claim settlement practices evident in procedures for rescinding coverage are eliminated.

- **Claims:** The examiners found four (4) areas of concern in their review of the claims handling practices of the Company. The following issues were identified:

    1. Failure, in some cases, to pay, deny or settle claims within the time periods required by Colorado insurance law.

    2. Failure, in some cases, to accurately process claims.

    3. Failure to accurately determine the number of days utilized for claim processing.

    4. Failure, in some instances, to pay late payment interest/penalties on claims.

It is recommended that the Company establish procedures to ensure payment, denial or settlement of claims within the time frames required by law. Procedures should also be established to ensure that the number of days utilized for claim processing is calculated correctly,
that late payment interest and penalties are paid in all applicable instances and claim procedures should be reviewed to ensure accuracy of benefit payments in all cases. Correct procedures should also be established for claims that are denied with a reason of "not medically necessary".

- **Utilization Review:** The examiners found eight (8) areas of concern in their review of utilization review procedures. The following issues were identified:

    1. Failure to reflect complete utilization review guidelines in an operational policy and procedures document.

    2. Failure to provide correct or complete information related to an insured's right to appeal adverse determinations.

    3. Failure to include all required elements in written notification letters for First Level Appeal Reviews.

    4. Failure to enter written First Level or any Second Level Review Appeals into the Complaint record.

    5. Failure to use correct procedures in conducting Utilization Review.

    6. Failure to provide telephone notification of determinations in all cases.

    7. Failure, in some cases, to use the correct method of notification for concurrent and retrospective review determinations.

    8. Failure to have notification of denials of claims for "not medically necessary" signed by a licensed physician

    It is recommended that procedures be established to ensure that Utilization Review is conducted in compliance with Colorado insurance law.

A copy of the Company's response, if applicable, can be obtained by contacting the Company or the Colorado Division of Insurance.

Results of previous Market Conduct Exams are available on the Colorado Division of Insurance's website at www.dora.state.co.us/insurance or by contacting the Colorado Division of Insurance.

MARKET CONDUCT EXAMINATION REPORT

FACTUAL FINDINGS

FORTIS INSURANCE COMPANY

COMPANY OPERATIONS / MANAGEMENT FINDINGS

Issue A1: Failure, in some cases, to maintain records required for market conduct purposes.

Regulation 1-1-7, Market Conduct Record Retention, Repealed and Repromulgated In Full under the authority of Section 10-1-109(1), C.R.S., states:

> Section 4. Records Required For Market Conduct Purposes
>
> A. *Every entity subject to the Market Conduct process shall maintain its books, records, documents and other business records in a manner so that the following practices of the entity subject to the Market Conduct process may be readily ascertained during market conduct examinations*, including but not limited to, company operations and management, policyholder services, claim's practices, rating, underwriting, marketing, complaint/grievance handling, producer licensing records, and additionally for health insurers/carriers or related entities: network adequacy, utilization review, quality assessment and improvement, and provider credentialing. Records for this regulation regarding market conduct purposes shall be maintained for the current calendar year plus two prior calendar years. [Emphasis added.]

The following represent instances in each of the respective sections of the market conduct examination when the Company has not maintained its records in a manner so that the practices of the Company can be readily ascertained during this market conduct examination:

Cancellations – Non-Renewals – Declinations - Rescissions

During the review of the sample of Cancelled-Non-Renewed files, the Company was unable to provide:

a. A copy of the reformation letter or exception rider for sample file number 12
b. A copy of the claim form initiating the investigation causing rescission for sample file number 32

During the review of the sample of Rescinded files, the Company was unable to provide:

a. A copy of the claim that initiated the investigation causing rescission for sample files numbered 25 and 32
b. A copy of the reformation letter offering a rider that was not returned causing sample file number 12 to be rescinded

Claims

There were 761 claims out of a population of 146,555 claims received in 2003 that had "U" (unknown) in the "Type of Submission" column. The Company was able only through manual research to determine if these 761 claims were submitted electronically or on paper.

Utilization Review

The Company was unable to provide a copy of the initial letter denying coverage to the claimant for the file identified below:

a. File No. 10 on Sample List of all UR decisions

The file identified below could not be provided.

b. File No. 34 on Sample List of all UR decisions

The Company was unable to provide documentation of the date additional information was requested for the file identified below:

c. File No. 31 on the Sample List of all UR decisions

Recommendation No. 1:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 1-1-7. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that all records required for market conduct examination purposes are maintained as required by Colorado insurance law.

Issue A2: Failure to submit an Annual Report and Certification of Forms in use or available for use in 2003.

Section 10-16-107.2, C.R.S., Filing of health policies, states:

> (1) All sickness and accident insurers, health maintenance organizations, and nonprofit hospital and health service corporations authorized by the commissioner to conduct business in Colorado shall submit an annual report to the commissioner listing any policy form, endorsement, or rider for any sickness, accident, nonprofit hospital and health service corporation, health maintenance organization, or other health insurance policy, contract, certificate, or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado. Such listing shall be submitted by January 15, 1993, and not later than December 31 of each subsequent year and shall contain a certification by an officer of the organization that each policy form, endorsement, or rider in use complies with Colorado law. The necessary elements of the certification shall be determined by the commissioner.

Amended Regulation 1-1-6, Concerning The Elements Of Certification For Accident and Health Forms, Private Passenger Automobile Forms, Commercial Automobile with Individually-Owned Private Passenger Automobile-Type Endorsement Forms, Claims-Made Liability Forms, Preneed Funeral Contracts and Excess Loss Insurance in Conjunction with Self-Insured Employer Benefit Plans under the Federal "Employee Retirement Income Security Act", promulgated pursuant to §§ 10-1-109, 10-4-419, 10-4-725, 10-15-105 and 10-16-107.2 and 10-16-119, C.R.S., states:

> Section 2. Purpose
>
> The purpose of this regulation is to promulgate rules applicable to filing of new policy form listings, annual reports of policy forms, and certifications of policy forms.
>
> Section 4. Definitions
>
> For the purposes of this regulation:
>
> D. "Annual Report for health coverage" shall mean a list of all policy forms, application forms (to include any health questionnaires used as part of the application process), endorsements and riders for any sickness, accident, and/or health insurance policy, contract, certificate, or other evidence of coverage currently in use and issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado, including the titles of the programs or products affected by the forms.

Section 5. Rules

C. Not later than December 31 of each year, each entity providing health care coverages shall file an Annual Report of policy forms including a fully executed certificate of compliance. …

Bulletin 9-00, Requirements for the Filing of Rates, Rules, and Forms for All Insurance Companies, effective August 3, 2000, states:

Section 1. Background and Purpose

The purpose of this Bulletin is to provide companies with comprehensive guidance on filing insurance rates, rules, and forms. This Bulletin replaces in its entirety Bulletin 9-99. Following these guidelines will reduce or eliminate incomplete or unsupported rate, rule, loss cost, and form filings, while providing greater protection to Colorado consumers. This Bulletin provides a standardized format for the certification of the forms as prescribed in Colorado Regulation 1-1-6, for each Listing of New Policy Forms or Annual Report of Policy Forms, and requires that health coverage compliance guides remain on file with the insurer. Additionally, the submission of a complete and supported filing should reduce costs to the insurance industry, Colorado consumers, and the Division of Insurance.

Colorado insurance law requires an Annual Report to the Commissioner listing any policy form, endorsement, rider or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado. Such listing shall be submitted no later than December 31 of each year. The Company has indicated that it did not file an Annual Report and Certification of Forms with the Division of Insurance in 2003

Recommendation No. 2:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-107.2, C.R.S. and Amended Regulation 1-1-6. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that an Annual Report and Certification of Forms is filed as required by Colorado insurance law.

Issue A3: Failure to comply with all applicable requirements of the Consumer Protection Standards Act For The Operation of Managed Care Plans, including maintaining an access plan for each managed care network offered in Colorado.

Section 10-16-102, C.R.S., Definitions, states:

(25.5) "Intermediary" means a person authorized by health care providers to negotiate and execute provider contracts with carriers on behalf of such providers.

(26.5) "Managed care plan" means a policy, contract, certificate, or agreement offered by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services through the covered person's use of health care providers managed by, owned by, under contract with, or employed by the carrier because the carrier either requires the use of or creates incentives, including financial incentives, for the covered person's use of those providers.

Section 10-16-702, C.R.S., Legislative declaration, states:

(1) The general assembly hereby finds, determines, and declares that the purposes of this part 7 are:

(b) To establish standards to assure the adequacy, accessibility, and quality of health care services offered under a managed care plan; and

(c) To establish requirements for written agreements between carriers offering managed care plans and participating providers regarding the standards, terms, and provisions under which the participating provider will provide services to covered persons.

Section 10-16-703, C.R.S., Applicability, states:

This part 7 applies to all managed care plans, except for workers' compensation and automobile insurance contracts, that are issued, renewed, extended, or modified on or after January 1, 1998.

Section 10-16-704(9), C.R.S., Network Adequacy, states:

Beginning January 1, 1998, a carrier shall maintain and make available upon request of the commissioner, the executive director of the department of public health and environment, or the executive director of the department of health care policy and financing, in a manner and form that reflects the requirements specified in paragraphs (a) to (k) of this subsection (9), an access plan for each managed care network that the carrier offers in this state. The carrier shall make the access plans, absent confidential information as specified in Section 24-72-204(3), C.R.S., *available on its business premises and shall provide them to any interested party upon request*. [Emphasis added.] In addition, all health benefit plans and marketing materials shall clearly disclose the existence and availability of the access plan. All rights and responsibilities of the covered person under the health benefit plan, however, shall be included in the contract provisions, regardless of whether or not such provisions are also specified in the access plan.

The carrier shall prepare an access plan prior to offering a new managed care network and shall update an existing access plan whenever the carrier makes any material change in an existing managed care network, but not less than annually. …

Section 10-16-705, C.R.S., Requirements for carriers and participating providers, states:

(1) In addition to any other applicable requirements of this part 7, a carrier offering a managed care plan shall satisfy all the requirements of this section.

Section 10-16-706. C.R.S., Intermediaries, states:

(1) In addition to any other applicable requirements of this part 7, a contract between a carrier and an intermediary shall satisfy all the requirements of this section.

(2) Intermediaries and participating provides with whom they contract shall comply with all the applicable requirements of section 10-16-705.

(3) The responsibility to ensure that participating providers have the capacity and legal authority to furnish covered benefits shall be retained by the carrier.

Section 10-16-707, C.R.S., Enforcement, states:

(1) If it is determined that a carrier has not contracted with enough participating providers to assure that covered persons have accessible health care services in a geographic area, that a carrier's access plan does not assure reasonable access to covered benefits, that a carrier has entered into a contract that does not comply with this part 7, or that a carrier has not complied with a provision of this part 7, the commissioner may institute a corrective action that shall be followed by the carrier or may use any of the commissioner's other enforcement powers to obtain the carrier's compliance with this part 7.

Regulation 4-2-15, Required Provisions in Carrier Contracts With Providers and Intermediaries Negotiating on Behalf of Providers, promulgated pursuant to Sections 10-1-109 and 10-16-121(5), Colorado Revised Statutes, states:

IV. Clarification of Terms

C. "Managed care plan" is defined in Section 10-16-102(26.5), C.R.S. Examples of managed care plans include but are not limited to: *preferred provider plans,* …, and *plans that provide different levels of benefits or claims payments depending on whether a covered person uses specified providers (sometimes called in-network providers).* [Emphasis added.]

The Company responded to a Comment Form issued for lack of an access plan, as follows:

> "We respectfully disagree with the examiner's interpretation of the Final Agency Order O-01-178. The relevant provision of the Order states that we failed to include or correctly describe required managed care provisions in provider and intermediary contracts. The Company agreed to amend its contracts in order to amicably resolve the examination; however, we did not agree with the Department's interpretation and application of the managed care requirements to the Company overall. In addition, the discussions with the Department in 2002 regarding this matter were never brought to final conclusion or resolution.
>
> We continue to maintain our position that our policies and certificates would not qualify as a managed care plan, as the term is defined under § 10-16-102(26.5), due to the fact that we do not manage, own, contract with or employ providers directly. Instead, our contracts are with the provider networks that, in turn, manage and/or contract with the individual providers. Due to the fact that the requirements of Part 7 of Article 16 of the Colorado Insurance Code only apply to managed care plans, we note that § 10-16-704 does not apply to the products offered by Fortis Insurance Company.

The Company also responded in part to a Comment Form issued for allowing balance billing, as follows:

> We continue to maintain our position that our policies and certificates would not qualify as a managed care plan, as the term is defined under § 10-16-102(26.5), due to the fact that we do not manage, own, contract with or employ providers directly. Instead, our contracts are with the provider networks that, in turn, manage and/or contract with the individual providers. Due to the fact that the requirements of Part 7 of Article 16 of the Colorado Insurance Code only apply to managed care plans, we note that § 10-16-704 does not apply to the products offered by Fortis Insurance Company.

The Colorado Division of Insurance has determined, and relayed to Fortis Insurance Company on multiple occasions in the past, its position that the Company is subject to the various requirements of the Consumer Protection Standards Act For The Operation Of Managed Care Plans. This determination was relayed to the Company in the Final Agency Order O-01-178, executed on February 21, 2001, and also in a June 4, 2002 letter to Christine F. Meyer, Esq., from Erin Toll, Esq., Director of Compliance for the Division of Insurance. Both of these documents reflect clearly the Division's position on the matter of Fortis Insurance Company being required to comply with all managed care plan provisions of Colorado law.

Recommendation No. 3:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-16-702, 10-16-703, 10-16-704, 10-16-705, 10-16-706, 10-16-707, C.R.S. and Amended Regulation 4-2-15. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has accepted the Division's determination that its PPO plans are considered "managed care plans", and that it has established procedures to ensure that it complies with all requirements of the Consumer Protection Standards Act For The Operation of Managed Care Plans.

UNDERWRITING
POLICY FORMS
FINDINGS

Issue E1: Failure to reflect that required repairs and replacements of prosthetic devices are to be covered.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(14) Prosthetic devices

(b) For the purposes of this subsection (14) "prosthetic device" means an artificial device to replace, in whole or in part, an arm or leg.

(e) Repairs and replacements of prosthetic devices are also covered, subject to copayments and deductibles, unless necessitated by misuse or loss.

The Company's most frequently sold individual policy in Colorado in 2003 does not appear to provide the mandatory coverage of repairs and replacements of prosthetic devices unless necessitated by misuse or loss. The policy form and Rider B098, filed with the Division of Insurance to be used no earlier than May 1, 2003, both exclude repairs and replacement of basic prosthetic devices.

The wording in the Policy is:

Covered Medical Services

Supplies and durable medical equipment for the lesser of the rental or purchase price. This coverage is limited to:

X basic prosthetic devices;

Repair, replacement or duplicates are not covered.

The wording in the Policy Amendment Rider is:

Page 1

The policy to which this rider is attached is amended as follows:

Supplies and durable medical equipment for the lesser of the rental or purchase price. This coverage is limited to:

X basic prosthetic devices;

Repair, replacement or duplicates are not covered, except for breast prostheses.

Form Number	Form Name
236	Preferred 2000, Physician/Hospital PPO
B098	Policy Amendment Rider

Recommendation No. 4:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its individual policy forms to reflect required coverage for repair and replacement of prosthetic devices as required by Colorado insurance law

Issue E2: Failure to disclose the existence and availability of an access plan.

Section 10-16-704, C.R.S., Network adequacy, states:

> (9) Beginning January 1, 1998, a carrier shall maintain and make available upon request of the commissioner, the executive director of the department of public health and environment, or the executive director of the department of health care policy and financing, in a manner and form that reflects the requirements specified in paragraphs (a) to (k) of this subsection (9), an access plan for each managed care network that the carrier offers in this state. The carrier shall make the access plans, absent confidential information as specified in Section 24-72-204(3), C.R.S., available on its business premises and shall provide them to any interested party upon request. In addition, *all health benefit plans* and marketing materials *shall clearly disclose the existence of and availability of the access plan.* … [Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that its most frequently sold health benefit plan does not clearly disclose the existence and availability of an access plan for its PHCS and Sloans Lake PPO networks.

Form Number	Form Name
236	Preferred 2000, Physician/Hospital PPO

Recommendation No.5:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-704, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to reflect the existence and availability of an access plan for each managed care network offered in Colorado as required by Colorado insurance law.

Issue E3: Failure to disclose the mandated hospitalization and general anesthesia benefit for dental procedures for dependent children.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(12) Hospitalization and general anesthesia for dental procedures for dependent children.

(a) All individual and all group sickness and accident insurance policies that are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article except supplemental policies that cover a specific disease or other limited benefit shall provide coverages for general anesthesia, when rendered in a hospital, outpatient surgical facility, or other facility licensed pursuant to section 25-3-101, C.R.S., and for associated hospital or facility charges for dental care provided to a dependent child, as dependent is defined in section 10-16-102 (14), of a covered person. Such dependent child shall, in the treating dentist's opinion, satisfy one or more of the following criteria:

(I) The child has a physical, mental, or medically compromising condition; or

(II) The child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or

(III) The child is an extremely uncooperative, unmanageable, anxious, or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred; or

(IV) The child has sustained extensive orofacial and dental trauma.

A review of the Company's most frequently sold policy in Colorado in 2003 revealed no indication of notification to the insured concerning the mandated coverage of hospitalization and general anesthesia for dental procedures for dependent children when certain criteria is met. Additionally there is a specific exception in the policy for dental care not related to a dental injury.

The wording on page 20 of the policy is:

Exclusions

We will not pay benefits for any of the following:

X Dental care not related to a dental injury

Form Number	Form Name
236	Preferred 2000, Physician/Hospital PPO

Recommendation No. 6:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to ensure that the mandatory hospitalization and general anesthesia coverage for dental procedures for dependent children is reflected as required by Colorado insurance law.

Issue E4: Failure to provide benefits for covered services based on a licensed provider's status, e.g., a family member or a legal guardian.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

> (7) Reimbursement of providers
>
> (a) Sickness and accident insurance.
>
> (I) (A) Notwithstanding any provisions of any policy of sickness and accident insurance issued by an entity subject to the provisions of part 2 of this article or a prepaid dental care plan subject to the provisions of part 5 of this article, whenever any such policy or plan provides for reimbursement for any service that may be lawfully performed by a person licensed in this state for the practice of osteopathy, medicine, dentistry, dental hygiene, optometry, psychology, chiropractic, or podiatry, reimbursement under such policy or plan shall not be denied when such service is rendered by a person so licensed. …

The Company's most frequently sold individual policy in Colorado in 2003 reflects an exclusion that does not appear to be in compliance with Colorado insurance law. A policy could contain an exclusion for charges that would not normally be billed if the member did not have insurance, but the policy may not exclude reimbursement for covered services performed by a licensed provider if the provider normally charges for the services, nor can a policy deny reimbursement for covered benefits based solely upon the provider's status, e.g., a family member or anyone with whom legal guardianship has been established.

The wording on page 19 of the policy is:

> **Exclusions**
>
> We will not pay benefits for any of the following:
>
> X Charges by a Health Care Practitioner or medical provider who is an immediate family member. Immediate family members are you, your spouse, your children, brothers, sisters, parents, their spouses and anyone with whom legal guardianship has been established.

Form Number	Form Name
236	Preferred 2000, Physician/Hospital PPO

Recommendation No. 7:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect that benefits may not be denied solely based on a provider's status (e.g. a family member or anyone with whom legal guardianship has been established), as required by Colorado insurance law.

Issue E5: Failure to allow for services appropriately provided through telemedicine.

Section 10-16-102, C.R.S., Definitions, states:

> (22) "Health care services" means any services included in the furnishing to any individual of medical, mental, dental, or optometric care or hospitalization or nursing home care or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human physical or mental illness or injury. "Health care services" includes the rendering of such services through the use of telemedicine.

Section 10-16-123, C.R.S., Telemedicine, states:

> (1) It is the intent of the general assembly to recognize the practice of telemedicine as a legitimate means by which an individual in a rural area may receive medical services from a provider *without person-to person contact with the provider*. [Emphasis added]
>
> (2) On or after January 1, 2002, no health benefit plan that is issued, amended, or renewed for a person residing in a county with one hundred fifty thousand or fewer residents *may require face-to-face contact between a provider and a covered person for services appropriately provided through telemedicine,* pursuant to section 12-36-06(1) (g), C.R.S., subject to all terms and conditions of the health benefit plan, if such county has the technology necessary for the provisions of telemedicine. [Emphasis added] Any health benefits provided through telemedicine shall meet the same standard of care as for in-person care. Nothing in this section shall require the use of telemedicine when in-person care by a participating provider is available to a covered person within the carrier's network and within the member's geographic area.

The Company's most frequently sold individual policy in Colorado in 2003 reflects an exclusion that does not appear to be in compliance with Colorado insurance law. The policy excludes all telemedicine or treatment rendered without the Health Care Provider being physically present with a patient and there are circumstances relating to the number of residents in a county when face-to-face contact between a provider and a covered person may not be required for services appropriately provided through telemedicine.

The wording on page 20 of the policy is:

Exclusions

We will not pay benefits for any of the following:

X Telemedicine or treatment rendered without the Health Care Provider being physically present with a patient.

Form Number	Form Name
236	Preferred 2000, Physician/Hospital PPO

Recommendation No. 8:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-123, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect the circumstances when telemedicine may be used, without the requirement of face-to-face contact between a provider and a covered person, as required by Colorado insurance law.

Issue E6: Failure to reflect a correct description of coverage to be provided for prostate cancer screenings.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

> (10)(a) Prostate Cancer Screening. All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, which are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any other group health care coverage offered to residents of this state, shall provide coverage *for annual screening for the early detection of prostate cancer in men over the age of fifty years and in men over the age of forty years who are in high-risk categories, which coverage by entities subject to part 2 or 3 of this article shall not be subject to policy deductibles.* Such coverage *shall be the lesser of sixty-five dollars per prostate cancer screening or the actual charge for such screening.* Such benefit shall in no way diminish or limit diagnostic benefits otherwise allowable under a policy. This coverage shall be provided according to the following guidelines: [Emphases added.]
>
> (III) *At least one screening per year shall be covered for any man fifty years of age or older*: [Emphasis added.]
>
> (IV) *At least one screening per year shall be covered for any man from forty to fifty years of age who is at increased risk of developing prostate cancer* as determined by the man's physician for an entity subject to part 2 or 3 of this article, or as determined by a participating physician for an entity subject to part 4 of this article. [Emphasis added.]

The Company's most frequently sold individual policy in Colorado in 2003 and a Copayment Rider do not appear to reflect correct information concerning the mandated coverage to be provided for prostate cancer screenings in the following ways:

<u>Incorrect</u>

(1) The only reference to the benefit to be paid for prostate cancer screenings in the policy is in the schedule of benefits, which indicates in-network will be paid at 80% and out-of-network will be paid at 60%. Colorado insurance law mandates this benefit to be the lesser of a specified amount ($65.00) per screening or the actual charge for such screening.

(2) Prostate Screenings are reflected as a wellness service in the policy. The

Copayment Rider amends this section with a requirement that wellness services are covered after coverage has been in effect for a selected number of months. (The sample rider provided reflects what looks like a bracketed – adjustable 12 months.) Colorado insurance law does not require coverage to have been in effect for any number of months before this mandated benefit is provided.

Incomplete

(1) Nothing appears to be reflected as to the guidelines by age or at increased risk for developing prostate cancer for the mandated benefit that is to be provided.

The wording on page 15 of the policy is as follows:

Wellness services include services based on the published recommendations of the U.S. Preventive Services Task Force and are subject to change. The maximum benefit payable for each calendar year is $(500). This maximum will not apply to routine mammograms, pap smears and prostate specific antigen (psa) tests and services for children up to age 13.

The Deductible will not apply to mammograms, pap smears, prostate specific antigen (psa) tests, and child preventive care services to age 13.

The wording in the one (1) page Copayment Rider is:

4. [The Wellness Services section in the Covered Medical Services provision is amended by adding the following:

   Wellness services are covered, subject to the plan Deductibles, and Rate of Payment,] after you have been insured under this rider for (12 months).]

Form Number	Form Name
236	Preferred 2000, Physician/Hospital PPO
2960	COPAYMENT RIDER

Recommendation No. 9:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect a correct description of coverage to be provided for prostate cancer screenings as required by Colorado insurance law.

Issue E7: Failure to reflect correct benefits to be provided for mammography screening.

Section 10-16-104, C.R.S., Mandatory Coverage Provisions, states:

(4) Low-dose mammography.

(a) For the purposes of this subsection (4), "low-dose mammography" means the X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, and film and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast. All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, which are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any other group health care coverage provided to residents of this state, shall provide coverage for *routine and certain diagnostic screening* by low-dose mammography for the presence of breast cancer in adult women. *Routine and diagnostic screenings* provided pursuant to subparagraph (II) or (III) of this paragraph (a) shall be provided on a contract year or a calendar year basis by entities subject to part 2 or 3 of this article and shall not be subject to policy deductibles. Such coverages shall be the lesser of sixty dollars per mammography screening, or the actual charge for such screening. *The minimum benefit required under this subsection (4) shall be adjusted to reflect increases and decreases in the consumer price index*. Benefits for routine mammography screenings shall be determined on a calendar year or a contract year basis, which shall be specified in the policy or contract. The routine and diagnostic coverages provided pursuant to this subsection (4) shall in no way diminish or limit diagnostic benefits otherwise allowable under a policy. … [Emphases added.] This mandated mammography coverage shall be provided according to the following guidelines:

(I) Provision of a single baseline mammogram for women thirty-five years of age and under forty years of age;

(II) Screening not less than once every two calendar years or contract years for women forty years of age and under fifty years of age, *as specified in the insured's policy or contract*, but at least once each such calendar year or contract year for a woman with risk factors to breast cancer as determined by her physician for an entity subject to part 2 or 3 of this article, or as

> determined by a participating physician for an entity subject to part 4 of this article; [Emphasis added.]
>
> (III) Annual screening, on a calendar year or contract year basis, for women who are fifty to sixty-five years of age.
>
> (b) The requirements of this section shall apply to all individual sickness and accident insurance policies and health care service or indemnity contracts issued on or after July 1, 1995, …

The Company's most frequently sold individual policy in Colorado in 2003 and a Copayment Rider do not appear to reflect correct information concerning the mandated coverage to be provided for mammography in the following ways:

Incorrect

(1) The word "routine" is the only descriptive word in the policy for the mammography benefit. The required coverage for mammograms in Colorado insurance law includes certain diagnostic screening as well as routine screenings.

(2) The only reference to the benefit to be paid for low-dose mammography in the policy is in the schedule of benefits which indicates in-network will be paid at 80% and out-of-network will be paid at 60%. There is a minimum benefit amount required for mammograms and this amount is to be adjusted on September 1st of each year to reflect increases and decreases in the consumer price index. From September 1, 2002 through August 31, 2003 the minimum benefit amount was $76.60 and from September 1, 2003 through August 31, 2004 the amount is $78.21.

(3) Mammograms are reflected as a wellness service in the policy. The Copayment Rider amends this section with a requirement that wellness services are covered after coverage has been in effect for a selected number of months. (The sample rider provided reflects what looks like a bracketed-adjustable 12 months) Colorado insurance law does not require coverage to have been in effect for any number of months before this mandated benefit is to be provided.

Incomplete

(1) Nothing appears to be reflected as to the guidelines by age or risk factors to breast cancer for the mandated mammography coverage to be provided.

The wording on page 15 of the policy is:

> **Covered Medical Services**
>
> **Wellness services** include services based on the published recommendations f the U.S. Preventive Services Task Force and are subject to change. The maximum benefit payable for each calendar year is $[500]. This maximum will not apply to routine mammograms, …

The Deductible will not apply to mammograms, …

The wording on page 3 of the policy is:

Schedule

Rate of Payment (unless listed elsewhere on this Schedule)	[Network 80%] Out-of-Network 60%]

The wording in the one (1) page Copayment Rider is:

4. [The Wellness Services section in the Covered Medical Services provision is amended by adding the following:

   Wellness services are covered, [subject to the plan Deductibles and Rate of Payment,] after you have been insured under this rider for [12 months].]

Form Number	Form Name
236	Preferred 2000, Physician/Hospital PPO
2960	COPAYMENT RIDER

Recommendation No. 10:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect a correct description of the benefits to be provided for mammography screening as required by Colorado insurance law.

Issue E8: Failure to include notification of the availability of and a description of the independent external review procedures in or attached to the policy.

New Regulation 4-2-21, External Review of Benefit Denials of Health Coverage Plans, promulgated and adopted by the commissioner of Insurance under the authority of §10-1-109, 10-16-109, 10-16-113(3)(b) and 10-16-113.5(4)(d), C.R.S., states:

> Section 5. Notice and Disclosure of Right to External Review
>
> B. (1) Effective for policies issued or renewed on or after June 1, 2000, each carrier shall include a description of the external review procedures *in or attached* to all health coverage plan materials dealing with the plan's grievance procedures including but not limited to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage it provides to covered persons. [Emphasis added.]
>
> (2) The description required under (1) of this Subsection B *shall include a notification of the availability of an external review process, the circumstances under which a covered person may use the external review process, the procedures for requesting an external review, and the timelines associated with an external review.* [Emphasis added.]

The Company does not appear to be in compliance with Colorado insurance law with regard to including notification with a complete description of the external review procedures *in or attached to* all health coverage plan materials dealing with the plan's grievance procedures. The only information concerning grievance procedures in the policy advises insureds to contact the Company for more information about formal grievance procedures. No other material to be attached to the policy dealing with grievance procedures was furnished to the examiners.

The wording on page 21 of the policy is:

OTHER PROVISIONS

Grievance Procedure

A complaint is any dissatisfaction you have regarding the services or benefits you receive from us. Call us with any complaint. We will attempt to resolve the complaint to your satisfaction. If we are unable to resolve the complaint over the phone, you can submit the complaint in writing as a formal grievance. Please contact us for more information about our formal grievance procedure.

Recommendation No. 11:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of New Regulation 4-2-21. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to include a description of the external review procedures as required by Colorado insurance law.

Issue E9: Failure to reflect only allowable exclusions for payment of life insurance benefits.

Section 10-7-109, C.R.S., Suicide no defense for nonpayment, states:

> The suicide of a policyholder *after the first policy year of any life insurance policy* issued by any life insurance company doing business in this state shall not be a defense against the payment of a life insurance policy, whether said suicide was voluntary or involuntary, and whether said policyholder was sane or insane. …

The Company has provided an Optional Term Life Rider used with its most frequently sold individual PPO policy in Colorado that has an exclusion for life insurance benefits that does not appear to be in compliance with Colorado insurance law. Suicide can be used as a defense for nonpayment only during the first year that a policy is in force, not the first two (2) years.

The wording on page 2 of the Rider is

EXCLUSIONS

We will not pay life benefits for death caused by:

Attempted suicide or self-inflicted injury, during the first two years coverage is in force.

Form Number	Form Name
2961	OPTIONAL TERM LIFE RIDER

Recommendation No. 12:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-7-109, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect only allowable exclusions for payment of life insurance benefits as required by Colorado insurance law.

Issue E10: Failure to allow benefits for accidental death to be paid when death results from suicide, attempted suicide or intentionally self-inflicted injury while insane.

Section 10-16-102(30), C.R.S., Health Care Coverage, Definitions, states:

> "Policy of sickness and accident insurance" means any policy or contract of insurance against loss or expense resulting from the sickness of the insured, or from the bodily injury or death of the insured by accident, or both.

Bulletin 8-99, issued October 22, 1999, states:

> Suicide Exclusions And Exclusions For
> Intentionally Self-Inflicted Injuries In Health Insurance Policies
>
> Section 1: Background and Purpose
>
> The Division of Insurance ("Division") has received consumer complaints concerning some health insurance carriers' usage and interpretations of suicide exclusions and exclusions for intentionally self-inflicted injuries in their policies. Some carriers are using exclusions to deny coverage for intentionally self-inflicted injuries, including suicide or attempted suicide, even where the injury, suicide or suicide attempt may be the result of sickness, accident or illness, which is covered under the policy. The exclusions at issue use language the same or substantially similar to the following: "benefits are excluded for treatment as a result of attempted suicide or suicide or intentionally self-inflicted injury, whether sane or insane." The purpose for this bulletin is to clarify the Division's position on this issue.
>
> Section 2: Applicability and Scope
>
> The subject matter of this bulletin concerns all health insurance carriers that use exclusions for intentionally self-inflicted injuries, including suicide and suicide attempts in their policies.
>
> Section 3: Division Position
>
> The Division adheres to the opinion of the Colorado courts that suicide, attempted suicide or other acts of self-destruction committed while insane are an accident. Those performing the above acts while insane are incapable of formulating the intent necessary to categorize the act as intentional. Therefore, insurance policies that provide coverage for sickness, accidents and illness, either as may be required by law (such as for mental illness) or otherwise, may not deny coverage for intentional acts committed while insane. Such exclusions are contrary to law and are void as against public policy. Accordingly, carriers are advised to amend policy language and interpret existing policy language accordingly.

The Company's Optional Term Life Rider, available with the most frequently sold policy in Colorado, reflects an exclusion for paying Accidental Death Benefits that does not appear to be in compliance

with Colorado insurance law which adheres to the opinion of the Colorado courts that suicide or other acts of self-destruction committed while insane are an accident.

The wording on page 2 of the Rider is:

ACCIDENTAL DEATH BENEFIT

We will pay an Accidental Death Benefit to your beneficiary upon due proof of your death, If your death:

1. Resulted directly and independently of disease, physical condition or bodily infirmity from bodily injuries caused solely by accident; and
2. Occurred within [180] days of your effective date.

Risks not covered:

No Accidental Death Benefits will be paid for death caused directly from:

1. Suicide, attempted suicide or intentionally self-inflicted injury, while sane or insane;

Form Number	Form Name
2961	OPTIONAL TERM LIFE RIDER

Recommendation No. 13:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-102, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised any applicable forms to reflect correct accidental death benefits to ensure compliance with Colorado insurance law.

Issue E11: Failure to reflect an accurate description of the mandated therapies for congenital defects and birth abnormalities for children.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

> (1.7) Therapies for congenital defects and birth abnormalities.
>
> (a) After the first thirty-one days of life, policy limitations and exclusions that are generally applicable under the policy may apply; except that all individual and group health benefit plans shall provide medically necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered children up to five years of age.
>
> (b) The level of benefits required in paragraph (a) of this subsection (1.7) *shall be the greater of the number of such visits provided under the policy or plan or twenty therapy visits per year each for physical therapy, occupational therapy, and speech therapy*. Said therapy visits shall be distributed as medically appropriate throughout the yearly term of the policy or yearly term of the enrollee coverage contract, without regard to whether the condition is acute or chronic and *without regard to whether the purpose of the therapy is to maintain or to improve functional capacity*. [Emphases added.]

The Company's most frequently sold plan in Colorado in 2003 does not appear to reflect an accurate description of the therapies mandated by Colorado insurance law for congenital defects and birth abnormalities for covered children up to five years of age in the following ways:

1. This therapy is to be provided without regard as to whether the purpose is to maintain or improve functional capacity. The Definitions section of the policy includes physical, occupational and speech therapy under Rehabilitation Services. The Covered Medical Services section of the policy reflects that Rehabilitation Services are not covered when the Company determines measurable progress toward expected outcomes has stabilized or is inconsistent.

2. The minimum level of benefits required to be available is twenty (20) visits per year for each of three types of therapy which correlates to a total of sixty (60) visits. The Covered Medical Services section of the policy reflects a calendar year benefit maximum for each covered person of thirty (30) days for Inpatient Rehabilitation services and a maximum benefit amount of $3,000 for Outpatient Rehabilitation services.

The wording on page 8 of the policy is:

Definitions

Rehabilitation Services	Services that include: X physical therapy, occupational therapy, speech therapy …

The wording on page 14 of the policy is:

Covered Medical Services

Rehabilitation Services include the following:
X Inpatient Rehabilitation Services up to [30] days each calendar year, and
X Outpatient Rehabilitation Services up to [$3,000] each calendar year.

Rehabilitation Services are not covered when we determine measurable progress toward expected outcomes has stabilized or is inconsistent. …

Form Number	Form Name
236	Preferred 2000, Physician/Hospital PPO

Recommendation No. 14:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect an accurate description of the mandated therapies for congenital defects and birth abnormalities for children, in compliance with Colorado insurance law.

Issue E12: Failure to reflect all required information in applications concerning replacement of coverage.

Repromulgated Regulation 4-2-1, REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE, promulgated under the authority of §§10-1-109 and 10-3-1110, Colorado Revised Statutes (C.R.S.) states:

Section 2. Purpose

The purpose of this regulation is to safeguard the interests of persons covered by individual accident and sickness insurance policies or plans who consider replacement of their coverage by making available to them information regarding replacement and thereby reducing the opportunity for misrepresentation and other unfair practices and methods of competition in the business of insurance.

Section 5. Rules

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has accident and sickness insurance in force or whether accident and sickness insurance is intended to replace or be in addition to any other accident and sickness insurance presently in force. A supplementary application or other form to be signed by the applicant and producer containing such questions and statements may be used.

[Statements]

(1) You normally do not require more than one policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid or Medicare and may not need an accident and sickness policy. If you are eligible for Medicare, you may want to purchase a Medicare Supplemental policy.

(4) If you are eligible for Medicare due to age or disability, counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program.

[Questions]

To the best of your knowledge:

(3) Are you covered for medical assistance through the state Medicaid program:

(a) As a Specified Low Income Medicare Beneficiary (SLMB)?

(b) As a Qualified Medicare Beneficiary (QMB)?

(c) For other Medicaid medical benefits?

The Company's paper applications for insurance do not appear to reflect any of the statements required by Colorado insurance law. One (1) of the applications reflects an incomplete question (3) and the other application does not reflect any part of question (3). No supplementary application or other form used for this purpose has been provided to the examiners.

The Company's E-Application does not appear to reflect any of the questions or any of the statements required by Colorado insurance law regarding replacement of other accident and sickness insurance.

Form 27016 (1/2000) Paper

- Does not reflect any of the required statements
- Does not reflect any of the three (3) ways an applicant could be covered for medical assistance through the state Medicaid program

Form 27931 3/2003 Paper

- Does not reflect any of the required statements
- Does not reflect a question three (3) concerning medical assistance through the state Medicaid program

Form 28032 E-Application

Recommendation No. 15:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 4-2-1. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its applications to reflect all of the statements and questions concerning replacement of coverage as required by Colorado insurance law.

Issue E13: Failure to reflect a correct definition of a dependent.

Section 10-16-102, C.R.S., Definitions, states:

> (14) "Dependent" means a spouse, an *unmarried child under nineteen years* of age, an unmarried child who is a *full-time student* under twenty-four years of age and who is *financially dependent* upon the parent, and an unmarried child of any age who is medically certified as disabled and dependent upon the parent. [Emphases added.]

The Company's most frequently sold policy in Colorado in 2003 does not appear to reflect a correct definition of a dependent in the following ways:

Incorrect

1. Colorado insurance law provides coverage for a child who is unmarried until the child becomes nineteen (19) years of age. The definition of a dependent in the policy does not reflect that a child should be unmarried and reflects eighteen (18) years of age instead of nineteen (19) years of age.

Incomplete

1. Nothing appears to be reflected for the requirement of a full-time student to be financially dependent upon the parent.

The wording on Page 6 of the policy is as follows:

Covered Dependent	X	The Policyholder's lawful spouse; or child who is *age 18 or less* and either a natural child, a child legally adopted or placed for adoption, or a stepchild. [Emphasis added.]
	X	If an unmarried child is age 23 or less, the child will be considered a Covered Dependent if you submit proof that the child meets the standards for a full-time student at an accredited educational institution. The student will be considered a Covered Dependent until the student is no longer a full-time student, graduates, attains age 24, or marries, whichever occurs first.

Form Number	Form Name
236	Preferred 2000, Physician/Hospital PPO

Recommendation No. 16:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-102, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect a correct definition of a dependent as required by Colorado insurance law.

Issue E14: Failure to reflect correct coverage for child health supervision services.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(11) Child health supervision services.

(a) For purposes of this subsection (11), unless the context otherwise requires, *"child health supervision services" means those preventive services and immunizations required to be provided in basic and standard health benefit plans pursuant to section 10-16-105 (7.2),* to dependent children up to age thirteen. [Emphasis added.] Such services shall be provided by a physician or pursuant to a physician's supervision or by a primary health care provider who is a physician's assistant or registered nurse who has additional training in child health assessment and who is working in collaboration with a physician.

(b) An individual, small group, or large group health benefit plan issued in Colorado or covering a Colorado resident that provides coverage for a family member of the insured or subscriber, shall, as to such family member's coverage, also provide that the health insurance benefits applicable to children include coverage for child health supervision services up to the age of thirteen. …

Amended Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

Attachment 1

COVERED PREVENTIVE SERVICES	
All Children	Immunizations. (Covered immunizations are listed at the end of this document.) Immunization deficient children are not bound by "recommended ages" on immunization chart
Age 0-12 months	1 newborn home visit during first week of life if newborn released from hospital less than 48 hours after delivery. 5 well-child visits [1] 1 PKU
Age 13-35 months	2 well child visits
Age 3-6	3 well child visits
Age 7-12	3 well child visits

The benefits for Child Health Supervision Services reflected in the Company's most frequently sold policy in Colorado in 2003 and a Copayment Rider do not appear to be correct for children up to age thirteen (13).

Incorrect:

(1) Child Health Supervision Service Benefits are reflected as a wellness service in the policy. The Copayment Rider amends this section with a requirement that wellness services are covered after coverage has been in effect for a selected number of months. (The sample rider provided reflects what looks like a bracketed-adjustable 12 months). Colorado insurance law does not require coverage to have been in effect for any number of months before this mandated benefit is to be provided.

Incomplete:

(1) There is no description of the benefits in the policy other than to state that a maximum benefit amount and the deductible do not apply.

(2) There is no list of covered immunizations or a statement that immunizations are based on the recommendations of the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians.

(3) Nothing is reflected to alert insureds that immunization deficient children are not bound by the recommended ages on the immunization chart.

The wording on page 15 of the policy is:

Covered Medical Services

Wellness services include services based on the published recommendations of the U.S. Preventive Services Task Force and are subject to change. The maximum benefit payable for each calendar year is $[500}. This maximum will not apply to routine mammograms, pap smears and prostate specific antigen (psa) tests, and *services for children up to age 13.* [Emphasis added.]

The Deductible will not apply to mammograms, pap smears prostate specific antigen (psa) tests, and child preventive care services to age 13.

The wording on page 1 of the Copayment Rider is:

4. [The Wellness Services section in the Covered Medical Services provision is amended by adding the following:

   Wellness services are covered, [subject to the plan Deductibles and Rate of Payment,] after you have been insured under this rider for [12 months].]

Form Number	Form Name
236	Preferred 2000, Physician/Hospital PPO
2960	COPAYMENT RIDER

Recommendation No. 17:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. and Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect correct benefits for child health supervision services as required by Colorado insurance law.

Issue E15: Failure to reflect correct disclosure information and determination questions on forms used for Business Groups of One purchasing individual coverage.

Section 10-8-601.5, C.R.S., Applicability and scope, states:

(1)(c)(I) Effective October 1, 1997, the provisions of this article and article 16 of this title concerning small employer carriers and small group plans shall not apply to an individual health benefit plan newly issued to a business group of one that includes only a self-employed person who has no employees, or a sole proprietor who is not offering or sponsoring health care coverage to his or her employees, together with the dependents of such a self-employed person or sole proprietor if, pursuant to rules adopted by the commissioner, all of the following conditions are met;

(A) As part of the application process, the carrier determines whether or not the applicant is a self-employed person who meets the definition of a business group of one pursuant to section 10-8-602 (2.5).

(E) As part of its application form, an individual carrier requires a business group of one self-employed person purchasing an individual health benefit plan pursuant to this subparagraph (I) to read and sign a disclosure form stating that, by purchasing an individual policy instead of a small group policy, such person gives up what would otherwise be his or her right to purchase a business group of one standard, basic, or other health benefit plan from a small employer carrier for a period of three years after the date the individual health benefit plan is purchased, unless a small employer carrier voluntarily permits such person to purchase a business group of one policy within such three-year period. The disclosure form shall also briefly describe the factors used to set rates for the individual policy being purchased in comparison with the factors used to set rates for a business group of one small group policy.

Amended Regulation 4-2-19, Concerning Individual Health Benefit Plans Issued To Self-Employed Business Groups Of One, promulgated pursuant to Sections 10-1-109(1), 10-8-601.5(1)(c)(I) and (3), 10-16-108.5(8), and 10-16-109, C.R.S., states:

V. Rules

A. An individual health benefit plan marketed and/or newly issued on or after October 1, 1997, to a self-employed business group of one, together with the dependents of the self-employed business group of one, shall be regulated as an individual health benefit plan instead of a small group health plan if the carrier issuing such policy, the policy itself, and the application for coverage meet all the following conditions:

1. Pursuant to Section 10-8-601.5(1)(c)(1)(A), C.R.S., the carrier issuing the policy shall determine whether or not the applicant is a self-employed business group of one. A carrier shall meet this requirement by having all applicants fill out the "Determination of Self-Employed Business Group of One Form" available from the Colorado Division of Insurance. A copy of the completed form shall be kept on file with each application. … Applicants who answer "yes" to all the questions in the form and, if required by the carrier, who can document their answers shall be considered to have met the test of a self-employed business group of one.

5. A carrier issuing an individual health benefit plan to a self-employed business group of one shall abide by the disclosure requirements as described in Section 10-8-601.5(1)(c)(I)(E), C.R.S. Accordingly:

    a) The carrier, as part of its application form, shall require each self-employed business group of one to read and sign a disclosure, as proscribed by the Division of Insurance, attesting that they understand that they are forfeiting their rights to purchase a business group of one standard, basic, or other health benefit plan from a small employer carrier for three years, as required by Section 10-8-601.5(1)(c)(I)(E), C.R.S.

Bulletin No. 12-01, Determination of Self-Employed Business Group of One Form and Disclosure form for Self-Employed Business Groups of One Applying for Individual Health Benefit Plans, states:

I. Background and Purpose

The purpose of this bulletin is to provide the form and disclosures required in Colorado Division of Insurance Regulation 4-2-19.

II. Applicability and Scope

This bulletin only applies to carriers offering and issuing individual health benefit plans to self-employed business groups of one *on or after January 1, 2002*. [Emphasis added.]

III. Division Position

A. Existing law requires an individual carrier to have all applicants complete the "Determination of Self-Employed Business Group of One

Form" prior to issuance of an individual policy. The bulletin provides the required form. The form is provided in Attachment I of this bulletin.

Attachment I

Determination of Self-Employed Business Group of One Form

1. Are you either a self-employed person with no employees, or a sole proprietor who is not offering or sponsoring health care coverage to your employees?

___ Yes
___ No

2. Have you carried on significant business activity as a self-employed person or sole proprietor for a period of at least one year prior to application for coverage?

___ Yes
___ No

3. Do you have *gross income* from your self-employment or sole proprietorship as indicated on Federal Internal Revenue forms 1040, Schedule C, F, or SE, or other forms recognized by the Federal Internal Revenue Service for income reporting purposes from which you have derived a substantial part of your income from your business as a self-employed person or sole proprietor for one year out of the past *three* years? *Note: Substantial part of your income" means income derived from business activities of the business group of one that are sufficient to pay for the annual premiums for the business group of one's health benefit plan*. [Emphases added.]

___ Yes
___ No

4. *Do you work a minimum of 24 hours a week on a permanent basis?* [Emphasis added.]

___ Yes
___ No

I, _[name of applicant]_____, attest that the answers to the questions contained in this form are true and correct.

Signature of Applicant: _____

Applicant's business: _____

Date: _____

B. Existing law requires an individual carrier, as part of its application form, to obtain a signed disclosure from a self-employed business group of one that is applying for an individual health benefit plan. The form shall include the following statements:

"Please read and sign the following disclosure required by Colorado law:

I, _(name of applicant), meet the definition of a self-employed business group of one as attested to on the accompanying Determination of Self-Employed Business Group of One Form. I understand that by purchasing an individual policy instead of a small group policy I give up what would otherwise be my right to purchase, during open enrollment periods as specified by law, a business group of one Standard, Basic, or other small group health benefit plan from a small employer carrier for a period of three (3) years after the effective date of the individual health benefit plan for which I am applying. I understand that this will be the case unless a small employer carrier voluntarily permits me to purchase a small group policy within such three (3) year period.

I understand that the factors used to set new and renewal rates for the individual policy I want to purchase consist of [NOTE: CARRIERS ENTER FACTORS HERE]. By comparison, the rating factors that would apply if I purchased a small group business group of one policy are limited to plan design, the carrier's overall cost and utilization trends ("index rate"), my age, my family size, and a factor that reflects the cost of care where I live.

The Business Group Of One Disclosure Statement used by the Company does not appear to be in compliance with Colorado insurance law in the following ways:

1. The underlined wording in the following sentence, first paragraph of the statement, is not reflected: "I understand that by purchasing an individual policy instead of a small group policy I give up what would otherwise be my right to purchase, during open enrollment periods as specified by law, a business group of one Standard, Basic, or other small group health benefit plan from a small employer carrier for a period of three (3) years after the effective date of the individual health benefit plan for which I am applying.
2. The second paragraph of the statement does not provide a comparison of the factors used to set rates for the individual policy being purchased with the factors used to set rates for a business group of one small group policy, but instead reflects a list of factors used to set rates for both types of policies. As a result the rating factors do not adhere to the limitations required by law for a small group business group of one policy.

3. One of the applications does not contain a Business Group Of One Disclosure Statement.

The Business Group Of One Disclosure Statement reflected on page 7 of the application is:

BUSINESS GROUP OF ONE DISCLOSURE STATEMENT

I,_____, meet the definition of a self-employed business group of one
(Signature of Applicant)
as attested to on the Determination of Self-Employed Business Group of One Form above. I understand that by purchasing an individual policy instead of a small group policy I give up what would otherwise be my right to purchase a business group of one Standard, Basic, or other small group health benefit plan from a small employer carrier for a period of three (3) years after the effective date of the individual health benefit plan for which I am applying. I understand that this will be the case unless a small employer carrier voluntarily permits me to purchase a small group policy within such three (3) year period.

The factors used to set rates for both an individual policy and a business group of one small group policy include the following: benefit options chosen, ages of each covered person, gender, smoker/non-smoker, health status, geographic location, medicare eligibility, health care cost trend, administrative costs, pre-existing conditions, claims experience of the plan, and length of time on the policy.

I was provided a copy of the health benefit plan description form for the plan for which I am applying and for the Colorado Standard Health Benefit plan.

The "Determination of Self-Employed Business Group of One Form" being used by the Company in 2003 does not appear to reflect correct or complete questions for this determination to be made.

Incorrect

Question 3 on the Company's form reflects:

- "taxable income" instead of "gross income".
- "two" previous years instead of "three" previous years

Incomplete

- There is no explanation of what constitutes a "substantial part of your income."
- There is no question on the Company's form asking if the applicant works a minimum of 24 hours a week on a permanent basis.
- One (1) of the two (2) Applications For Medical Insurance does not reflect a "Determination of Self-Employed Business Group of One Form.

Page 7 of the Application that does reflect a "Determination Of Self-Employed Business Group Of One Form", reads:

3. Do you have taxable income from you self-employment or sole proprietorship as indicated on Federal Internal Revenue forms 1040, Schedule C, F, or SE, or other forms recognized by the Federal Internal Revenue Service for income reporting purposes which generated taxable income in one of the two previous years?

Form Number	Form Name
27016 (rev. 1/2000)	Application For Medical Insurance
27931	Application For Medical Insurance (This application did not reflect a disclosure statement or a Determination of Self-Employed Business Group of One Form)

Recommendation No. 18:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-8-601.5, C.R.S. and Amended Regulation 4-2-19. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms used for Business Groups of One applying for individual coverage to reflect correct disclosure information and determination questions as required by Colorado insurance law.

Issue E16: Failure to reflect correct coverage to be provided for home health services and hospice care.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(8) Availability of hospice care coverage.

(d) The commissioner, in consultation with the department of public health and environment, may establish by rule and regulation requirements for standard policy and plan provisions which state clearly and completely the criteria for and extent of insured coverage for home health services and hospice care. Such provisions shall be designed to facilitate prompt and informed decisions regarding patient placement and discharge.

Amended Regulation 4-2-8, Concerning Required Health Insurance Benefits For Home Health Services And Hospice Care, promulgated under the authority of Sections 10-1-109 and 10-16-104(8)(d), C.R.S., states:

Section 2. Purpose

The purpose of this regulation is to establish requirements for standard policy provisions, which state *clearly and completely the criteria for and extent of coverage for home health services and hospice care* and to facilitate prompt and informed decisions regarding patient placement and discharge. [Emphasis added.]

Section 4. Requirements for Home Health Services

A. Definitions.

(2) "Home health services" means the following services provided by a certified home health agency under a plan of care to eligible persons in their place of residence:

(b) *Certified nurse aide services* as defined in §12-38.1-102(3), C.R.S.; [Emphasis added.]

(d) Physical therapy, occupational therapy or speech pathology and *audiology services*, as such therapy and services are defined in C.R.S. [Emphasis added.]

(3) "Home health visit" is each visit by a member of the home health team, provided on a part-time and intermittent basis as included in the plan of care. *Services of up to 4 hours by a home health aide shall be considered as one visit.* [Emphasis added.]

B. General Policy Provisions Pertaining to Home Health Care.

(1) The policy offering shall provide that home health services are to be covered when such services are necessary as a*lternatives to hospitalization or in place of hospitalization. Prior hospitalization shall not be required.* [Emphasis added.]

C. Benefits for Home Health Care Services.

(3) The policy offered shall include benefits for the following services:

(b) *Certified nurse aide services* under the supervision of a Registered Nurse or a qualified therapist;

(e) Speech therapy and *audiology*;

(f) Respiratory and *inhalation* therapy; [Emphases added.]

Section 5. Requirements for Hospice Care

A. Definitions.

(4) *A "patient/family" is one unit of care consisting of those individuals who are closely linked with the patient, including the immediate family, the primary care giver and individuals with significant personal ties*. [Emphasis added.]

(12) *"Home care services" are hospice services, which are provided in the place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility*. [Emphasis added.]

(15) "Hospice levels of care:"

(c) "Inpatient hospice respite care." The level of care received when the patient is in a licensed facility to provide the caregiver a period of relief. Inpatient respite care may be provided only on an intermittent, non-routine, short-term basis. It may be limited to periods of five days or less.

(16) "Bereavement" is that period of time during which survivors mourn a death and experience grief. Bereavement services

mean support services to be offered during the bereavement period.

(18) A "benefit period" for hospice care services is a period of three months, during which services are provided on a regular basis.

(19) A "hospice per diem" rate is the predetermined rate for each day in which an individual is enrolled in a hospice program and under its care, without regard to which, if any, services are actually provided on a specific day.

B. General Provisions Pertaining to Hospice Care

(1) The policy offering shall provide that hospice care services are to be covered when such services are provided under active management through a hospice which is responsible for coordinating all hospice care services, regardless of the location or facility in which such services are furnished.

(2) The policy offering shall provide that benefits are allowed only for individuals who are terminally ill and have a life expectancy of six months or less, except that benefits may exceed six months should the patient continue to live beyond the prognosis for life expectancy, in which case the benefits shall continue at the same rate for one additional benefit period. *After the exhaustion of three benefit periods, the insurer's case management staff shall work with the individual's attending physician and the hospice's Medical Director to determine the appropriateness of continuing hospice care*. [Emphasis added.]

(5) The policy offering shall clearly indicate that services and charges incurred in connection with an unrelated illness will be processed in accordance with policy coverage provisions applicable to all other illnesses and/or injuries.

C. Benefits for Hospice Care Services

(2) The policy or certificate may contain a dollar limitation on routine home care hospice benefits. Other services provided by or through the hospice that are available to the insured will be negotiated at a hospice per diem rate with the hospice provider. *Any policy offered shall provide a benefit of no less than $100 per day* for any combination of the following routine home care services, which are planned, implemented and evaluated by the interdisciplinary team:

(a) Intermittent and 24 hour on-call professional nursing services provided by or under the supervision of a Registered Nurse;

(b) Intermittent and 24 hour on-call social/counseling services; and;

(c) Certified nurse aide services or nursing services delegated to other persons pursuant to § 12-38-132, C.R.S.

The total benefit for each benefit period for these services shall not be less than the per diem benefit multiplied by ninety-one (91) days. [Emphasis added.]

(3) *The policy offering shall include the following benefits, subject to the policy's deductible, coinsurance and stoploss provisions, which are exclusive of and shall not be included in the dollar limitation for hospice care benefits as specified in (2) above*: [Emphasis added.]

(a) Bereavement support services for the *family* of the deceased person during the *twelve month period following death*, and in no event shall this maximum benefit *be less than $1150*. [Emphases added.]

(b) Short-term general inpatient (acute) hospice care or continuous home care which may be required during a period of crisis, for pain control or symptom management and shall be paid consistent with any other sickness or illness (i.e., not included in the per diem limitation specified in (2) above). Such care shall require prior authorization of the interdisciplinary team and may, except for emergencies, weekends or holidays, require prior authorization by the insurer, provided, however, that the insurer may not require prior authorization when the transfer to the higher level of care was necessary during the insurer's non-business hours if the hospice seeks the authorization during the insurer's first business day;

(c) Medical supplies;

(d) Drugs and biologicals;

(e) Prosthesis and orthopedic appliances;

(f) Oxygen and respiratory supplies;

(g) Diagnostic testing;

(h) Rental or purchase of durable equipment;

(i) Transportation;

(j) Physicians services;

(k) Therapies including physical, occupational and speech; and

(l) Nutritional counseling by a nutritionist or dietitian.

The Company's most frequently sold policy in Colorado in 2003 does not completely describe the mandated home health care benefits in the following ways:

Incomplete

There is nothing reflected concerning the definition of what constitutes a "home health visit", that services of up to 4 hours by a home health aide shall be considered as one visit.

The provision that home health services are to be covered when services are necessary as alternatives to hospitalization, or in place of hospitalization and that prior hospitalization is not required is not reflected.

The policy does not reflect services provided by a Certified nurse aid as a covered medical service.

There is nothing reflected concerning the fact that inhalation therapy and audiology are home health services to be provided.

The Company's most frequently sold individual policy in Colorado in 2003 does not appear to reflect correctly or completely the extent of coverage to be provided for hospice care services in the following ways:

Incorrect

1. A limitation for bereavement support services is reflected that appears to be more limited than allowed by Colorado insurance law. A "patient/family" is one unit of care consisting of those individuals who are closely linked with the patient, including the primary care giver and individuals with significant personal ties. Individuals other than covered dependents would be entitled to bereavement support services. Bereavement support services for the family of the deceased person are to be provided during the twelve month period following

death, not the three month period after the insured's death. Additionally, in no event is the maximum benefit to be less than $1,150, not $1,077 as reflected in the policy.

2. There are twelve benefits for hospice care services that are to be governed by the deductible and coinsurance of the overall policy. The policy schedule of benefits reflects that the rate of payment and the deductible are waived for Hospice Care Services.

Incomplete

1. Nothing is reflected concerning the fact that "Home care services" are hospice services, which are provided in the place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility.

2. Nothing is reflected concerning the "Inpatient hospice respite care", one of the hospice levels of care that is to be covered when provided on an intermittent, non-routine, short-term basis and that may be limited to periods of five days or less.

3. Nothing is reflected to indicate that a "benefit period" for hospice care services is a period of three months, during which services are provided on a regular basis.

4. Nothing is reflected identifying the twelve (12) benefits (except for bereavement support services) which are subject to the deductible, coinsurance and stoploss provisions, but are exclusive of and not to be included in the dollar limitation for hospice care per diem benefits.

5. Nothing is reflected to indicate that benefits are allowed only for individuals who have a life expectancy of six months or less, except that benefits may exceed six months should the patient continue to live beyond the prognosis for life expectancy, in which case the benefits shall continue at the same rate for one additional benefit period. Additionally, after the exhaustion of three benefit periods, the insurer's case management staff shall work with the individual's attending physician and the hospice's Medical Director to determine the appropriateness of continuing hospice care.

6. Nothing is reflected to indicate that services and charges incurred in connection with an unrelated illness will be processed in accordance with policy coverage provisions applicable to all other illnesses and/or injuries.

7. Nothing is reflected to indicate that a benefit of no less than $100 is to be provided per day for three (3) routine home care services and the total benefit for each benefit period for these services shall not be less than the per diem benefit multiplied by ninety-one (91) days.

8. Nothing is reflected concerning the benefit of short-term general inpatient (acute) hospice care or continuous home care, to be paid consistent with any other sickness or illness, which may be required during a period of crisis, for pain control or symptom

management nor the requirements for prior authorization of this type of hospice care service.

The wording on page 3 of the policy is:

Schedule

Medical Deductible	
Individual medical deductible each calendar year (January 1-December 31	$ [500]
Maximum family medical Deductible each calendar year	$ [1,000]
Prescription Drug Deductible	
Individual Prescription Drug deductible each calendar year	$ [500]
Maximum family Prescription Drug Deductible each calendar year	$ [1,000]
Rate of Payment (unless listed elsewhere on this Schedule)	[Network 80%]
	Out-of-Network 60%]
Non-Preferred Brand Name Prescription Drugs	80%]

The wording on page 4 of the policy is:

Schedule

Rate of Payment and Deductible Waived

Hospice Care Services
Home Health Care Services
Inpatient Rehabilitation Services

The wording on page 6 of the policy is:

Definitions

Covered Dependent The Policyholder=s (sic) lawful spouse; or child who is age 18 or less and either a natural child, a child legally adopted or placed for adoption, or a stepchild.

Deductible The amount of Covered Charges you must pay each calendar year before we pay benefits. Once [two or more Insureds have collectively met] the maximum family medical Deductible, no additional Deductible will be taken during the calendar year.

The medical Deductible amount is shown on the Schedule.

The wording on page 13 of the policy is:

Covered Medical Services

Covered Medical Services include only Covered Charges for the services and supplies listed in the policy.
Home health care services provided by a home health care agency up to [240] hours each calendar year for visits by a state-licensed nurse, respiratory therapist, and services included in a preauthorized Health Care Practitioner's plan of treatment (including nutrition counseling and medical social services). A home health care agency is a state-licensed organization certified by Medicare to provide home health care.
Hospice care services provided in either an Inpatient, Outpatient or home setting. A state licensed hospice must be Medicare certified and/or accredited by the Joint Commission on Accreditation of Healthcare Organization (JCAHO).

Hospice care includes bereavement counseling by a licensed clinical social worker for Covered Dependents during the three month period after the Insured=s (sic) death, up to a maximum benefit of $[1077].

Recommendation No. 19:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. and Amended Regulation 4-2-8. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect correct coverage for home health services and hospice care as required by Colorado insurance law.

Issue E17: Failure to reflect the coverage to be provided for inherited enzymatic disorders.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(1)(a) All group and individual sickness and accident insurance policies and all service or indemnity contracts issued by any entity subject to part 3 or 4 of this article shall provide coverage for a dependent newborn child of the insured or subscriber from the moment of birth.

(c)(III)(A) Coverage for inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids shall include, but not be limited to, the following diagnosed conditions: Phenylketonuria; maternal phenylketonuria; maple syrup urine disease; tyrosinemia; homocystinuria; histidinemia; urea cycle disorders, hyperlysinemia; glutaric acidemias; methylmalonic academia; and propionic academia. Covered care and treatment of such conditions shall include, to the extent medically necessary, medical foods for home use for which a physician who is a participating provider has issued a written, oral, or electronic prescription.

(B) There is no age limit on benefits for inherited enzymatic disorders specified in sub-subparagraph (A) of this paragraph (III) except for phenylketonuria. The maximum age to receive benefits for phenylketonuyria is twenty-one years of age; except that the maximum age to receive benefits for phenylketonuria for women who are of child-bearing age is thirty-five years of age.

(C) As used in this subparagraph (III), "medical foods," means prescription metabolic formulas and their modular counterparts, obtained through a pharmacy, that are specifically designated and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and for which medically standard methods of diagnosis, treatment, and monitoring exist. Such formulas are specifically processed or formulated to be deficient in one or more nutrients and are to be consumed or administered enterally either via tube or oral route under the direction of a physician who is a participating provider. This sub-subparagraph (C) shall not be construed to apply to cystic fibrosis patients or lactose- or soy-intolerant patients.

(D) Coverage of medical foods, as provided under this subparagraph (III), shall only apply to insurance plans that include an approved pharmacy benefit and shall not apply to alternative medicines. Such

coverage shall only be available through participating pharmacy providers. Nothing in this subparagraph (III) shall be construed as preventing a carrier from imposing deductibles, coinsurance, or other cost-sharing methods.

The Company's most frequently sold individual policy in Colorado in 2003 does not appear to reflect any mention of the mandatory coverage for inherited enzymatic disorders and in addition the description of covered prescription drugs appears to be limited to prescription drugs and medicines which would not include payment of benefits for "medical foods", which is one of the treatments for such conditions.

The wording on page 17 of the policy is:

Covered Prescription Drug Services

Covered Prescription Drug services include only Covered Charges for the services and supplies listed in this policy. Charges are subject to all the terms, limits and conditions of this plan.

For Prescription Drugs and medicines we will pay [up to $2,000] each year] for the following:

X legend drugs and medicines that by Federal law can only be obtained with a prescripton;
X injectable insulin or Imitrex with a prescription; and
X disposable insulin syringes, and disposable blood/urine, glucose/acetone testing agents or lancets.

Form Number	Form Name
236	Preferred 2000, Physician/Hospital PPO

Recommendation No. 20:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect the coverage to be provided for inherited enzymatic disorders as required by Colorado insurance law.

Issue E18: Failure to reflect a correct definition of what qualifies as creditable coverage for purposes of reducing preexisting condition limitations.

Section 10-16-102, C.R.S., Definitions, states:

(13.7) "Creditable coverage" means benefits or coverage provided under:

(a) Medicare or Medicaid;

(b) An employee welfare benefit plan or group health insurance or health benefit plan;

(c) An individual health benefit plan;

(d) A state health benefits risk pool (including but not limited to CoverColorado); or

(e) Chapter 55 of title 10 of the United States code, a medical care program of the federal Indian health service or of a tribal organization, a health plan offered under chapter 89 of title 5, United States code, a public health plan, or a health benefit plan under section 5 (e) of the federal "Peace Corps Act" (22 U.S.C. Sec. 2504 (e))

The Company's definition in its most frequently sold individual policy sold in Colorado in 2003 of what qualifies as "creditable coverage" that can be used for reducing a preexisting conditions limitation, does not appear to be correct or complete in the following ways:

Incomplete

1. The following types of plans are not reflected:

   - Chapter 5 of title 10 of the United States code
   - A medical care program of the federal Indian health service or of a tribal organization
   - A health plan offered under chapter 89 of title 5, United States code
   - A public health plan
   - A health benefit plan under section 5 (e of the federal "Peace Corps Act" (22 U.S.C. Sec. 504 (e))

Incorrect

1. There is no provision in Colorado insurance law for adding the additional qualifier of the previous coverage having to provide benefits similar or exceeding the benefits provided under the basic health benefit plan.

The wording on page 19 of the policy is:

Preexisting Conditions Limitation

Qualifying prior health plan means Medicare or Medicaid; an employer based health insurance plan or any other health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan; or an individual health insurance policy (including coverage issued by a health maintenance organization, a prepaid hospital or medical care plan, and a fraternal benefit society plan) that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan.

Form Number	Form Name
236	Preferred 2000, Physician/Hospital PPO

Recommendation No. 21:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-102, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect a correct and complete definition of what qualifies as creditable coverage for purposes of reducing preexisting condition limitations as required by Colorado insurance law.

Issue E19: Failure to reflect correct provisions required in individual policies.

Section 10-16-202, C.R.S., Required provisions in individual sickness and accident policies, states:

(1) Except as provided in section 10-16-204, each such policy delivered or issued for delivery to any person in this state *shall contain the provisions specified in this section in the words in which the same appear in this section;* except that the insurer, at its option, may substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. … [Emphasis added.]

(5) (a) *A provision as follows: "Reinstatement:* If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. If the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy *shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date*. [Emphasis added.] In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, *but not to any period more than sixty days prior to the date of reinstatement.*" [Emphasis added.]

(10)(a) A provision as follows: "Payment of claims: *Indemnity for loss of life will be payable in accordance with the beneficiary designation* and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be paid to the insured." [Emphasis added.]

(b) The following provisions, or either of them, may be included with the provision set forth in paragraph (a) of this subsection (10) at the option of the insurer: …

"Subject to *any written direction of the insured* in the application or otherwise, all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical or surgical services may, *at the insurer's option and* unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person." [Emphases added.]

(11) A provision as follows: "Physical examinations and autopsy: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to *make an autopsy* in case of death where it is not forbidden by law." [Emphasis added.]

The Company's most frequently sold individual policy in Colorado during 2003 does not appear to reflect correct and complete provisions required in individual policies in the following ways:

The reinstatement provision does not reflect that a premium accepted in connection with reinstatement may not be applied to any period more than sixty days prior to the date of reinstatement. Additionally it does not reflect that in the case of reinstated policies, the Company will cover only loss resulting from an accidental injury that occurs after the date of reinstatement and loss due to such sickness that begins more than ten days after such date.

The provision for Payments of claims incorrectly reflects that benefits for indemnity due to loss of life are paid at the insurer's option instead of in accordance with any beneficiary designations and the provisions respecting such payments. In addition, the information concerning payment for health related benefits is incomplete in that it does not include the requirement that the insured must provide written direction to the insurer for benefits to be payable at the insurer's option.

The provision concerning Physical examinations and autopsy does not reflect the Company's right during the review of a claim to make an autopsy, where law does not forbid it, for determining payment of benefits.

The wording on page 9 is:

When Your Coverage Begins and Ends

Reinstatement

If any premium is not paid within the time required, your coverage will lapse. We will reinstate your coverage, provided:

X the lapse was not more than 6 months.

After your coverage is reinstated, you and Fortis Insurance Company will have the same rights as existed before your coverage lapsed.

The wording on page 12 is as follows:

How to File a Claim for Benefits

Claim Payment

We pay either you or your provider for covered services. Upon your death, we will pay benefits at our option to your spouse, the providers of the treatment or your estate.

The wording on page 22 is as follows:

Physical Exams

We have the right to have a Health Care Practitioner examine you while a claim is pending. We will pay for the cost of these examinations.

Form Number	Form Name
236	Preferred 2000, Physician/Hospital PPO

Recommendation No. 22:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-202, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect correct provisions for individual policies as required by Colorado insurance law.

Issue E20: Failure to reflect correct or complete elements in the CoverColorado Notice Form.

Amended Regulation 4-6-3, Concerning CoverColorado Standardized Notice Form And Eligibility Requirements, promulgated by the Commissioner of Insurance under the authority of §§ 10-1-109 and 10-8-520, C.R.S., states:

> Section 4. Rules
>
> C. Elements of the CoverColorado Notice Form for Adverse Underwriting Decisions
>
> The elements of notification as determined by the Commissioner, which must be given to individuals with adverse underwriting decisions are:
>
> Applicant/Insured's:
>
> 1. Name.
>
> 2. Policy number (if applicable).
>
> 3. Reasons for notice: rejection of coverage, health rate higher than the rate available through CoverColorado or coverage that will be reduced by a restrictive rider or by excluding coverage for a pre-existing condition longer than six months or involuntarily terminated for reasons other than nonpayment of premium.
>
> 4. That the individual and dependents are eligible for the health care coverage through CoverColorado.
>
> 5. Name, address, contact person, and telephone number of CoverColorado Administrative Office to which interested persons should be referred.
>
> 6. Name and phone number of underwriter or other contact at the carrier's office.
>
> 7. A statement that the applicant may receive information about the available CoverColorado benefits and exclusions by contacting the CoverColorado Administrative Office.

Bulletin No. 13-01, Concerning CoverColorado Standardized Notice Form For Health Insurers, states:

> III. Effective January 1, 2002, all carriers authorized to conduct business in Colorado and offer health benefit plans are to provide the attached CoverColorado Notice Form to individuals who are eligible for coverage under the Colorado Uninsurable Health Insurance Plan as prescribed under

10-8-513, C.R.S.

This form is attached to this Bulletin as Exhibit A. Reproduction by insurers is authorized. Insurers may print the CoverColorado Plan Notice form on their own stationary but *should use the order, format and content as specified*. [Emphasis added.]

EXHIBIT A

COVERCOLORADO PLAN NOTICE FORM

Issued: December 7, 2001
For more information regarding CoverColorado, please contact:

CoverColorado
1700 Broadway, Ste 430
Denver CO 80290
303-863-1960

Reissued: April 1, 2002
For more information regarding CoverColorado, please contact:

CoverColorado
425 S. Cherry Street # 160
Glendale, CO 80246
303-863-1960

The Company's CoverColorado Standardized Notice Form For Health Insurers does not appear to reflect correct or complete content in the following ways:

Incorrect: The address and telephone number reflected in the Company's form for obtaining information about the CoverColorado program is:

Cover Colorado
1700 Broadway, Suite 430
Denver, CO 80290
303-863-1960

Incomplete: The following reasons requiring the CoverColorado Notice Form are not reflected:

You had a health plan involuntarily terminated by a carrier in this state for any reason other than nonpayment of premium and is effective within the sixty-two (62) days after termination of such individual's prior coverage; or

You meet the definition of a federally eligible individual under Colorado Revised Statute 10-16-105.5, and are not subject to the eligibility requirements of Colorado Revised Statute 10-8-513. A dependent of a federally eligible individual shall be eligible for coverage under CoverColorado if the dependent

satisfies the definition of "dependent" under Colorado Revised Statute 10-16-102(14). A federally eligible individual means an individual:

> Who has of the date on which the individual seeks coverage, the aggregate of periods of creditable coverage is eighteen months or more and the most recent prior creditable coverage was under a group health plan. As used in definition, "group health plan" means an employee welfare benefit plan as defined in 29 U.S.C., Sec. 1002(1) of the federal "Employee Retirement Income Security Act of 1974" to the extent that the plan provides health care services, including items and services paid for as health care services, to employees or their dependents directly or through insurance reimbursement or otherwise. A "Group Health plan" includes a government or church plan.
>
> Who is not eligible for coverage under a group health benefit plan, Medicare, or Medicaid and does not have other health benefit plan coverage;
>
> Whose most recent coverage was not terminated as a result of nonpayment of premium or fraud; and
>
> Who did not turn down an offer of continuation coverage if it was offered and who subsequently exhausted such coverage.

Form Number	Form Name
None	COVERCOLORADO PLAN NOTICE FORM

Recommendation No. 23:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-3. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect correct and complete elements in the CoverColorado Notice Form as required by Colorado insurance law.

Issue E21: Failure to reflect that forty-eight (48) or ninety-six (96) hours hospital stay coverage is to be provided for newborns.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(1) Newborn children.

(a) All group and individual sickness and accident insurance policies and all service or indemnity contracts issued by any entity subject to part 3 or 4 of this article shall provide coverage for a dependent newborn child of the insured or subscriber from the moment of birth.

(b) (I) Coverage for a hospital stay for a newborn following a normal vaginal delivery shall not be limited to less than forty-eight hours. If forty-eight hours following delivery falls after 8 p.m., coverage shall continue until 8 a.m. the following morning.

(II) Coverage for a hospital stay for a newborn following a cesarean section shall not be limited to less than ninety-six hours. If ninety-six hours following the cesarean section falls after 8 p.m., coverage shall continue until 8 a.m. the following morning.

The Company's exclusion for routine nursery charges for newborns in its most frequently sold individual policy in Colorado in 2003 does not appear to be in compliance with the requirements of Colorado insurance law to provide coverage for a hospital stay for a newborn for at least forty-eight or ninety-six hours depending on the type of delivery regardless of whether maternity coverage is provided. Additionally, the Company has indicated that no maternity rider was sold with this policy form.

The wording on page 20 of the policy is:

Exclusions

We will not pay benefits for any of the following:

X Maternity and routine nursery charges unless you have a Maternity Rider.

Form Number	Form Name
236	Preferred 2000, Physician/Hospital PPO

Recommendation No. 24:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect that depending on the type of delivery, forty-eight (48) or ninety-six (96) hours hospital stay coverage is to be provided for newborns as required by Colorado insurance law.

Issue E22: Failure to reflect correct information concerning allowable reasons for termination of coverage.

Section 10-16-201.5, C.R.S., Renewability of health benefit plans – modification of health benefit plans, states:

(1) A carrier providing coverage under a health benefit plan *shall not discontinue coverage or refuse to renew such plan except for the following reasons*: [Emphasis added.]

(a) Nonpayment of the required premium;

(b) Fraud or intentional misrepresentation of material fact on the part of the plan sponsor with respect to group health benefit plan coverage and the individual with respect to individual coverage;

(d)(I) The carrier elects to discontinue offering and nonrenew all of its individual, small group, or large group health benefit plans delivered or issued for delivery in this state. In such case the carrier shall provide notice of the decision to discontinue or not to renew coverage to all policyholders and covered persons and to the insurance commissioner in each state in which an affected individual is known to reside at least one hundred eighty days prior to the discontinuance or nonrenewal of the health benefit plan by the carrier. The carrier shall also discontinue and nonrenew all of its individual or small or large group health benefit plans in Colorado. Notice to the insurance commissioner under this paragraph (d) shall be provided at least three working days prior to the notice to the affected individuals.

(f) *With respect to individual health benefit plans, the commissioner finds* that the continuation of the coverage would not be in the best interest of the policyholders or certificate holders, the plan is obsolete, or would impair the carrier's ability to meet its contractual obligations. *Once the commissioner has made such a finding, the carrier shall provide notice to each covered individual provided coverage of this type of such discontinuation at least ninety days prior to the date of discontinuation and shall provide each affected covered individual the opportunity to purchase any other individual health insurance coverage being offered by the carrier*. [Emphases added.]

(4) An individual health benefit plan must clearly disclose in its contracts and marketing materials the conditions of renewability which conform with the requirements of this section.

The Company's most frequently sold individual plan in Colorado for 2003, does not appear to reflect information that is in compliance with Colorado insurance law concerning discontinuance of coverage in the following ways:

1. The policy reflects that if an insured has a PPO Plan and moves outside of the service area the policy will terminate.

2. The policy reflects that coverage will terminate if a particular form of individual health plan is non-renewed in the state in which the policy was issued or the state in which the insured presently resides. This is an action that can only be taken if one (1) of three (3) specific situations is a finding of and approved by the Commissioner. In this situation there is also a time frame within which covered individuals shall be notified of the action and the carrier has to provide each affected individual the opportunity to purchase any other individual health insurance coverage being offered by the carrier.

3. The policy reflects that coverage will terminate if the covered individual becomes eligible for Medicare, if allowed by federal law.

4. The policy does not reflect the allowable reason, with notification requirements, of the carrier electing to discontinue offering and nonrenew all of its individual health benefit plans delivered or issued for delivery in the state of Colorado.

The wording on page 9 of the policy is:

When Your Coverage Begins and Ends

Termination

The Policyholder may cancel this coverage at any time by sending us written notice. Upon cancellation, we will promptly return the unearned portion of any premium paid.

This policy will terminate at 12:01 a.m. standard time at the Policyholders (sic) residence on the date:

X requested in writing or the date we receive the request, whichever is later;
X for nonpayment of premium;
X there is fraud or material misrepresentation made by or with the knowledge of any insured applying for this coverage or filing a claim for benefits;
X if all policies with the same form number are nonrenewed in the state in which your policy was issued or the state in which you presently reside;
X if you have a PPO plan and move outside of the service area;
X you become eligible for Medicare, if allowed by federal law; or
X you are no longer a Covered Dependent.

Form Number	Form Name
236	Preferred 2000, Physician/Hospital PPO

Recommendation No. 25:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-201.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect information concerning discontinuance of coverage that is in compliance with Colorado insurance law.

Issue E23: Failure to maintain and provide the Standard Health Benefit Plan Description Form to Business Groups of One applying for an individual plan.

Section 10-8-601.5, C.R.S., Applicability and scope, states:

(1)(c)(I) Effective October 1, 1997, the provisions of this article and article 16 of this title concerning small employer carriers and small group plans shall not apply to an individual health benefit plan newly issued to a business group of one that includes only a self-employed person who has no employees, or a sole proprietor who is not offering or sponsoring health care coverage to his or her employees, together with the dependents of such a self-employed person or sole proprietor if, pursuant to rules adopted by the commissioner, all of the following conditions are met;

(E) As part of its application form, an individual carrier requires a business group of one self-employed person purchasing an individual health benefit plan pursuant to this subparagraph (I) to read and sign a disclosure form stating that, by purchasing an individual policy instead of a small group policy, such person gives up what would otherwise be his or her right to purchase a business group of one standard, basic, or other health benefit plan from a small employer carrier for a period of three years after the date the individual health benefit plan is purchased, unless a small employer carrier voluntarily permits such person to purchase a business group of one policy within such three-year period. The disclosure form shall also briefly describe the factors used to set rates for the individual policy being purchased in comparison with the factors used to set rates for a business group of one small group policy. *The individual carrier shall provide to the business group of one self-employed applicant a copy of the health benefit plan description form for the Colorado standard health benefit plan in addition to the description form for the individual plan being marketed. … [Emphasis added]*

Bulletin No. 12-01, Determination of Self-Employed Business Group of One Form and Disclosure form for Self-Employed Business Groups of One Applying for Individual Health Benefit Plans, states:

I. Background and Purpose

The purpose of this bulletin is to provide the form and disclosures required in Colorado Division of Insurance Regulation 4-2-19.

III. Division Position

A. Existing law requires an individual carrier, as part of its application form, to obtain a signed disclosure from a self-employed business

> group of one that is applying for an individual health benefit plan. The form shall include the following statements:
>
> "Please read and sign the following disclosure required by Colorado law:
>
> I, (name of applicant), meet the definition of a self-employed business group of one as attested to on the accompanying Determination of Self-Employed Business Group of One Form. I understand that by purchasing an individual policy instead of a small group policy I give up what would otherwise be my right to purchase, during open enrollment periods as specified by law, a business group of one Standard, Basic, or other small group health benefit plan from a small employer carrier for a period of three (3) years after the effective date of the individual health benefit plan for which I am applying. I understand that this will be the case unless a small employer carrier voluntarily permits me to purchase a small group policy within such three (3) year period.
>
> I understand that the factors used to set new and renewal rates for the individual policy I want to purchase consist of [NOTE: CARRIERS ENTER FACTORS HERE]. By comparison, the rating factors that would apply if I purchased a small group business group of one policy are limited to plan design, the carrier's overall cost and utilization trends ("index rate"), my age, my family size, and a factor that reflects the cost of care where I live.
>
> *I have been given a health plan description form showing the benefits under Colorado's small group Standard Health Benefit Plans.* [Emphasis added.] …

The Company responded to a request for a specimen copy of its Standard Health Benefit Plan Description Form as follows:

> Please note that Fortis Insurance Company discontinued the use of the Standard Health Benefit Plan Description Form used to show the benefits under Colorado's small group Standard Health Benefit Plans when it left the Small Group market in 2001; therefore, we did not use the Standard Health Benefit Plan Description Form in Colorado in 2003.

Colorado insurance law requires carriers, as part of application forms, to obtain a signed disclosure from a self-employed business group of one that is applying for an individual health benefit plan. This is one of the conditions that allow business groups of one applying for individual health benefit plans to be exempt from the provisions concerning small employer carriers and small group plans. The disclosure states that the applicant was provided a copy of the health benefit plan description for the Colorado Standard Health Benefit plan which it appears could not have been done as the Company was unable to furnish one and has indicated none was used in Colorado in 2003.

The wording on page 7 of an Application used by the Company for individual medical coverage reflects:

BUSINESS GROUP OF ONE DISCLOSURE STATEMENT

I was provided a copy of the health benefit plan description form for the plan for which I am applying and for the Colorado Standard Health Benefit plan.

Recommendation No. 26:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-8-601.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it maintains and provides a Standard Health Benefit Plan Description Form to Business Groups of One applying for an individual plan in compliance with Colorado insurance law.

Issue E24: Failure to include all required information in Certificates of Creditable Coverage.

Amended Regulation 4-2-18, Concerning The Method of Crediting and Certifying Creditable Coverage For Pre-existing Conditions, promulgated by the Commissioner under the authority granted in Sections 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S., states:

II. Purpose And Background

The purpose of this regulation is to establish the method health coverage plans must use to credit and certify creditable coverage when determining exclusions for pre-existing conditions as required by Section 10-16-118(1)(b), C.R.S. The purpose of the 1999 amendments to this regulation is to update the regulation as part of the Executive Order Review Process (Executive Order D0004 97).

III. Applicability And Scope

This amended regulation shall apply to all health coverage plans which are issued or renewed on or after November 1, 1999.

V. Rules

A. Application of federal laws concerning creditable coverage

1. The method for crediting and certifying creditable coverage for determining pre-existing condition limitations, as required by Section 10-16-118(1)(b), C.R.S., shall be as set forth in federal regulations promulgated pursuant to HIPAA, with the following exceptions:

    a. Those exceptions specifically enumerated in this regulation; and

    b. Where Colorado law exists on the same subject and has different requirements that are not pre-empted by federal law, Colorado law shall prevail.

2. The federal regulations found in 45 C.F.R. 146.113(a)(3), (b) and (c); 45 C.F.R. 146.115; 45 C.F.R. 146.117: 45 C.F.R. 146.119(b); and 45 C.F.R. 146.125 (a)(3), (b), (d) and (e) adopted by the Department of Health and Human Services are hereby incorporated by reference, and shall have the force of Colorado law, in accordance with Section 24-4-103(12.5), C.R.S. These federal regulations concern methods of counting creditable coverage, requirements concerning a health plan's duty to provide certificates of creditable coverage to insureds, special enrollment periods, the effective dates for certification requirements, transition rules for counting creditable coverage, and transition rules for certificates of creditable coverage. This rule does not include later

amendments to, or editions of, the above-referenced regulations. Interested parties are encouraged to refer to the summary and supplementary information concerning the incorporated regulations which begins in Volume 62, number 67, page 16894 of the Federal Register, April 8, 1997, for assistance in interpreting the federal regulations.

B. Exception: Minimum ninety (90) day gap for creditable coverage

Colorado law requires health coverage plans to waive any exclusionary time periods applicable to a pre-existing condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than ninety (90) days prior to the effective date of the new coverage. Colorado law prevails over the federal regulations.

The Certificate of Creditable Coverage being used by the Company does not appear to include all the information required by Federal laws that are incorporated by reference in Colorado Amended Regulation 4-2-18. Item 7 of the Model Certificate of Individual Health Insurance Coverage reflects information concerning a "significant break in coverage" and does not appear to be reflected in the Company's Certificate. The sixty-three (63) day break in coverage that is reflected in the Federal laws is incorrect for the state of Colorado which allows ninety (90) days. For Certificates of Creditable Coverage used in Colorado, it is recommended that the correct time period of ninety (90) days be used with a notation that this applies to Colorado only.

NOTE: Amended Regulation 4-2-18, applying to all certificates of creditable coverage issued on or after October 1, 2004, has incorporated the correct definition of a "significant break in coverage" in Section 4.

The wording in the Company's Certificate of Creditable Coverage is:

CERTIFICATE OF CREDITABLE COVERAGE

The purpose of this letter is to provide certification of coverage for the primary insured and/or dependents who have loss of coverage through the above referenced Individual Medical policy.

When applying for future health coverage, this information will assist other insurance carriers in determining the reduction of any preexisting condition period. **PLEASE RETAIN THIS MPORTANT INFORMATION WITH YOUR OTHER INSURANCE RECORDS.** The time period for coverage is reflected between the effective and termination dates below.

Primary Insured's Name Application Receipt Date Effective Date Term Date

If any of the above information is incorrect, please contact a Member Service Specialist at 1-800-553-7654. A new certificate will be remailed to you.

Form No.	Form Name
CCC	CERTIFICATE OF CREDITABLE COVERAGE

Recommendation No. 27:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-18. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its Certificates of Creditable Coverage to reflect information concerning a significant break in coverage as required by Colorado insurance law.

UNDERWRITING APPLICATIONS FINDINGS

Issue G1: Failure to automatically provide Colorado Health Plan Description Forms during the application process.

Section 10-16-108.5, C.R.S., Fair marketing standards, states:

(11)(a) Effective January 1, 1998, all carriers offering or providing health benefit plan coverage or medicare supplemental coverage shall make available a Colorado health benefit plan description form for each policy, contract, and plan of health benefits that either covers a Colorado resident or is marketed to a Colorado resident or such resident's employer.

(d) A carrier shall provide a completed Colorado health benefit plan description form each of its health benefit plans;

(II) *As part of its marketing materials, to any person or employer who may be interested in purchasing or obtaining coverage under such a plan*. …[Emphasis added.]

Amended Regulation 4-2-20, Concerning The Colorado Comprehensive Health Benefit Plan Description Form, promulgated pursuant to Sections 10-1-109, 10-3-1110(1), 10-16-108.5(11)(b), and 10-16-109, C.R S., states:

Section 4. RULES

E. Carriers shall provide a Colorado Health Plan Description Form as follows:

b. *Automatically* within three (3) business days of a potential policyholder expressing interest in a particular plan (e.g., "I am interested in the Gold Plan, the $500 deductible PPO plan, your Medicare HMO plan with vision care coverage, etc.," or "I want to purchase your Plan 200, $5 copay HMO plan," etc.): [Emphasis added.]

F. 1. Carriers shall prominently include with all marketing materials the following notice:

"Colorado law requires carriers to make available a Colorado Health Plan Description Form, which is intended to facilitate comparison of health plans. *The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan*. …[Emphasis added.]

Bulletin 2-98, Distribution and use of the Colorado Comprehensive Health Benefit Description Form, Issue and Effective Date: April 14, 1998, states:

I. BACKGROUND & PURPOSE

In 1997, the Colorado General Assembly passed legislation (HB 97-1311) requiring all carriers to use a standard benefit description form for health benefit plans issued or renewed on and after January 1, 1998. (See Section 10-16-108.5(1), C.R.S.) In November 1997, the Division of Insurance promulgated Insurance Regulation 4-2-20, which established and implemented rules concerning the format for, elements of, and issuance of the Colorado Health Benefit Description Form. Both the regulation and HB 97-1311 specified the circumstances under which the form must be distributed.

It has come to the attention of the Division of Insurance that some carriers are not following the rules for distributing the form. …
The purpose of this bulletin is (1) to remind carriers of Colorado's requirements concerning the distribution of the Colorado Health Benefit Description Form, …

II. ACTION NECESSARY

A. Carriers are reminded that Colorado Insurance Regulation 4-2-20 requires all carriers to provide a Colorado Health Plan Description Form, which is specific with respect to the particular policy provisions of the policy it is marketing, selling, or has issued, under the following circumstances:

3. As part of the policyholder's and, if different, the certificate holder's application for coverage before an application for coverage is actually filled out; [Emphasis added.]

The Company has indicated that it or the agents provide Colorado Health Plan Description Forms to applicants upon request. This does not appear to be in compliance with Colorado insurance law that Health Plan Description Forms are to be automatically provided during the application process prior to an application for coverage actually being filled out.

Recommendation No. 28:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-108.5, C.R.S. and Amended Regulation 4-2-20. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that Health Plan Description Forms are automatically provided during the application process as required by Colorado insurance law.

Issue G2: Failure to issue CoverColorado Notices in some required instances.

Section 10-8-503, C.R.S., Definitions. As used in this part 5, unless the context otherwise requires:

(17.3) "Program" or "CoverColorado" means CoverColorado and its administration and implementation of the health benefit plans permitted under this part 5.

Section 10-8-513, C.R.S., Eligibility for coverage under the program, states:

(1) Except for those individuals who meet the criteria set forth in subsection (2) of this section and except as provided in section 10-8-513.5, any individual who is a resident of this state, unless exempted by subsection (4) of this section, and who has been residing in the United States under the color of law for at least six months, including children who have been placed for adoption, as defined in Section 10-16-104 (6.5) or are under the legal guardianship of a resident of Colorado, shall be eligible for coverage under the program, if such individual is able to provide evidence satisfactory to the administering carrier that such individual meets one of the following conditions:

(a) Such individual has applied to a carrier for a health benefit plan and:

(I) Such application has been rejected or refused because of the health or medical condition of the applicant; or

(II) Such application has been accepted, but at a premium rate exceeding the rate available through the program; or

(III) *Such application was accepted with a reduction or exclusion of coverage for a pre-existing medical or health condition for a period exceeding six months.* [Emphasis added.]

(b) Such individual has a history of any medical or health condition that is on the presumptive conditions list adopted by the board pursuant to section 10-8-506 (1) (g.5).

(c) Such individual has had a health benefit plan involuntarily terminated by a carrier in this state for any reason other than nonpayment of a premium or premiums.

Section 10-8-521, C.R.S., Notice to residents, states:

If any individual who is a resident of this state applies to a carrier for a health benefit plan and the carrier responds to such application as described in section 10-8-513 (1)(a), or if any federally eligible individual applies to a carrier for a health benefit plan, the carrier shall give the individual written notice that the individual may be

eligible for coverage under the program, including information about available benefits, exclusions, and premium subsidies, and the name, address, and telephone number of the program.

Amended Regulation 4-6-3, Concerning CoverColorado Standardized Notice Form And Eligibility Requirements, promulgated by the Commissioner of Insurance under the authority of §§ 10-1-109 and 10-8-520, C.R.S., states:

Section 4. Rules

B. Notification Requirements for Individuals with Adverse Underwriting Decisions

1. In order to comply with § 10-8-521, C.R.S., all carriers giving notice to an applicant or insured of one or more of the following adverse underwriting determinations shall be required to give notice to the applicant or insured that he or she may be eligible for coverage under CoverColorado. Dependents of participants are also eligible for coverage under the program. The adverse underwriting decisions which require the applicant/insurer to notify the applicant/insured are:

   a. The applicant is rejected for insurance because of the medical condition or history of the applicant; or

   b. The application was accepted, but the premium rate for insurance exceeds the rate available through CoverColorado; or

   c. Coverage will be reduced, limited by a restrictive rider or by the exclusion of coverage for a pre-existing condition for longer than six months.

2. Carriers shall be required to complete the CoverColorado Notice Form for every adverse underwriting determination listed above. Carriers may print the CoverColorado Notice Form on their own stationary but shall use the order, format and content of the CoverColorado Notice Form, as prescribed by the Commissioner of Insurance.

A sample of one hundred new business application files was randomly selected for review. It was noted that eighteen (18) of these files that were issued with a reduction or exclusion of coverage for a pre-existing medical or health condition for a period exceeding six months, did not indicate that the required notice of eligibility for the CoverColorado program had been sent.

NEW BUSINESS-APPLICATION FILES

Population	Sample	Number of Exceptions	Percentage to Sample
6,698	100	18	18%

Recommendation No. 29:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-8-503, 10-8-513, 10-8-521, C.R.S. and Amended Regulation 4-6-3. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that CoverColorado Notices are issued in all instances required by Colorado insurance law.

UNDERWRITING
CANCELLATIONS/NON-RENEWALS/DECLINATIONS
FINDINGS

Issue H1: Failure, in some cases, to issue Certificates of Creditable Coverage.

Amended Regulation 4-2-18, Concerning The Method of Crediting and Certifying Creditable Coverage For Pre-existing Conditions, promulgated by the Commissioner under the authority granted in Sections 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S., states:

II. Purpose And Background

The purpose of this regulation is to establish the method health coverage plans must use to credit and certify creditable coverage when determining exclusions for pre-existing conditions as required by Section 10-16-118(1)(b), C.R.S. The purpose of the 1999 amendments to this regulation is to update the regulation as part of the Executive Order Review Process (Executive Order D0004 97).

V. Rules

A. Application of federal laws concerning creditable coverage

1. The method for crediting and certifying creditable coverage for determining pre-existing condition limitations, as required by Section 10-16-118(1)(b), C.R.S., shall be as set forth in federal regulations promulgated pursuant to HIPAA, with the following exceptions:

   a. Those exceptions specifically enumerated in this regulation; and

   b. Where Colorado law exists on the same subject and has different requirements that are not pre-empted by federal law, Colorado law shall prevail.

2. The federal regulations found in 45 C.F.R. 146.113(a)(3), (b) and (c); 45 C.F.R. 146.115; 45 C.F.R. 146.117; 45 C.F.R. 146.119(b); and 45 C.F.R. 146.125 (a)(3), (b), (d) and (e) adopted by the Department of Health and Human Services are hereby incorporated by reference, and shall have the force of Colorado law, in accordance with Sections 24-4-103(12.5), C.R.S. These federal regulations concern methods of counting creditable coverage, requirements concerning a health plan's duty to provide certificates of creditable coverage to insureds, special enrollment periods, the effective dates for certification requirements, transition rules for counting creditable coverage, and transition rules for certificates of creditable coverage. This rule does not include later amendments to, or editions of, the above-referenced regulations. Interested parties are encouraged to refer to the summary and supplementary information concerning the incorporated regulations which begins in Volume 62, number 67, page 16894 of the Federal Register, April 8, 1997, for assistance in interpreting the federal regulations.

A random sample of fifty (50) cancelled/non-renewed files was chosen for review. The request for the sample of Cancelled/Non-Renewed files asked that documentation for each file be furnished that included issuance of Certificates of Creditable Coverage. It does not appear that Certificates of Creditable Coverage were issued for the insureds covered by seven (7) of the terminated policies.

CANCELLED/NON-RENEWED FILES

Population	Sample	Number of Exceptions	Percentage to Sample
4,130	50	7	14%

Recommendation No. 30:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-18. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that Certificates of Creditable Coverage are issued to all insureds terminating medical coverage as required by Colorado insurance law.

Issue H2: Failure to provide written notice of eligibility for coverage under CoverColorado in some required cases.

Section 10-8-503, C.R.S., Definitions, As used in this part 5, unless the context otherwise requires:

(17.3) "Program" or "CoverColorado" means CoverColorado and its administration and implementation of the health benefit plans permitted under this part 5.

Section 10-8-513, C.R.S., Eligibility for coverage under the program, states:

(1) Except for those individuals who meet the criteria set forth in subsection (2) of this section and except as provided in section 10-8-513.5, any individual who is a resident of this state, unless exempted by subsection (4) of this section, and who has been residing in the United States under the color of law for at least six months, including children who have been placed for adoption, as defined in section 10-16-104 (6.5) or are under the legal guardianship of a resident of Colorado, shall be eligible for coverage under the program, if such individual is able to provide evidence satisfactory to the administering carrier that such individual meets one of the following conditions:

(a) Such individual has applied to a carrier for a health benefit plan and:

(II) Such application has been rejected or refused because of the health or medical condition of the applicant; or

(III) Such application has been accepted, but at a premium rate exceeding the rate available through the program; or

(IV) Such application was accepted with a reduction or exclusion of coverage for a preexisting medical or health condition for a period exceeding six months.

(b) Such individual has a history of any medical or health condition that is on the presumptive conditions list adopted by the board pursuant to section 10-8-506(1) (g.5).

(c) Such individual has had a health benefit plan involuntarily terminated by a carrier in this state for any reason other than nonpayment of a premium or premiums. [Emphasis added.]

Section 10-8-521, Notice to residents, states:

If any individual who is a resident of this state applies to a carrier for a health benefit plan and the carrier responds to such application as described in section 10-8-513(1)(a), or if any federally eligible individual applies to a carrier for a health benefit plan, the carrier shall give the individual written notice that the individual may be eligible for coverage under the program, including information about

available benefits, exclusions, and premium subsidies, and the name, address, and telephone number of the program.

Amended Regulation 4-6-3, Concerning CoverColorado Standardized Notice Form And Eligibility Requirements, promulgated by the Commissioner of Insurance under the authority of §§ 10-1-109 and 10-8-520, C.R.S., states:

Section 4. Rules

B. Notification Requirements for Individuals with Adverse Underwriting Decisions

1. In order to comply with § 10-8-521, C.R.S., all carriers giving notice to an applicant or insured of one or more of the following adverse underwriting determinations shall be required to give notice to the applicant or insured that he or she may be eligible for coverage under CoverColorado. Dependents of participants are also eligible for coverage under the program. The adverse underwriting decisions which require the insurer to notify the applicant/insured are:

a. The applicant is rejected for insurance because of the medical condition or history of the applicant; or

b. The application was accepted, but the premium rate for insurance exceeds the rate available through CoverColorado; or

c. Coverage will be reduced, limited by a restrictive rider or by the exclusion of coverage for a pre-existing condition for longer than six months.

2. Carriers shall be required to complete the CoverColorado Notice Form for every adverse underwriting determination listed above. Carriers may print the CoverColorado Notice Form on their own stationery but shall use the order, format and content of the CoverColorado Notice Form, as prescribed by the Commissioner of Insurance.

3. The carrier shall attach a copy of the CoverColorado Program Notice Form to the notice of adverse underwriting determination sent to an applicant for insurance. The carrier shall attach a copy of the Notice Form to a copy of the policy and endorsement when it is sent to the insured in the case of an individual being accepted for health insurance coverage but at a premium rate exceeding the rate available through the CoverColorado Program.

C. Elements of the CoverColorado Notice Form for Adverse Underwriting Decisions

The elements of notification as determined by the Commissioner, which must be given to individuals with adverse underwriting decisions are:

Applicant/Insured's:

1. Name.

2. Policy number (if applicable).

3. Reasons for notice: rejection of coverage, health rate higher than the rate available through CoverColorado or coverage that will be reduced by a restrictive rider or by excluding coverage for a pre-existing condition longer than six months or involuntarily terminated for reasons other than nonpayment of premium.

4. That the individual and dependents are eligible for the health care coverage through CoverColorado.

5. Name, address, contact person and telephone number of CoverColorado Administrative Office to whom interested persons should be referred.

6. Name and telephone number of underwriter or other contact at the carrier's office.

7. A statement that the applicant may receive information about the available CoverColorado benefits and exclusions by contacting the CoverColorado Administrative Office.

The Company provided a population of thirty-eight (38) individual policies that were rescinded in 2003 in Colorado. This population was used as the sample to be reviewed. All the policies were rescinded for medical conditions or medical history not revealed in the application but discovered when medical records were received in investigation of a claim. Some of the medical conditions or histories, if known, would have resulted in no coverage being issued and in other cases, the insureds were offered the option of having the coverage limited by restrictive riders. Only three (3) of the thirty-eight (38) files in the sample of rescinded policies contained documentation of written notice of eligibility for coverage under the CoverColorado program.

RESCINDED FILES

Population	Sample	Number of Exceptions	Percentage to Sample
38	38	35	92%

A random sample of fifty (50) declined files was selected for review. It does not appear that a notice of eligibility for coverage under the CoverColorado program was sent to applicants for coverage in four (4) of these files that were declined because of the medical condition or history of the applicant or because the applicant declined to accept a restrictive rider reducing or limiting coverage.

DECLINED FILES

Population	Sample	Number of Exceptions	Percentage to Sample
699	50	4	8%

Recommendation No. 31:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-8-513 and 10-8-521, C.R.S. and Amended Regulation 4-6-3. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that written notice of eligibility for coverage under the CoverColorado program is issued as required by Colorado insurance law.

Issue H3: Failure to affirm or deny coverage within a reasonable time resulting in unreasonable delays in rescinding coverage.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:

(V) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

The examiners reviewed the population of thirty-eight (38) files in which the Company had rescinded the insured's coverage for policies effective in 2003. In twenty-six (26) files, identified on the Comment Forms, it appears that the Company failed to affirm or deny coverage of claims within a reasonable time after receipt of the claims that initiated the investigation leading to rescission of the coverage. This resulted in an unreasonable delay in rescinding coverage. The Company indicated in its letters of rescission, that had medical health information indicated in medical records obtained after receipt of the claims, been indicated on the applications for coverage, one of the following would have applied:

1. The coverage would not have been issued
2. The coverage would have required removal of preferred rates
3. The coverage would have required medical restrictions
4. Coverage would have been excluded for one of the applicants

In the cases involving removal of preferred rates, medical restrictions and exclusion of coverage for one of the applicants, riders or amendments were offered but not accepted by the policyholder.

RESCINDED FILES

Population	Sample	Number of Exceptions	Percentage to Sample
38	38	26	68%

Recommendation No. 32:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-3-1104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure compliance with Colorado insurance law in elimination of any unfair claim settlement practices evident in rescinding coverage.

CLAIMS
FINDINGS

Issue J1: Failure, in some cases, to pay, deny or settle claims within the time periods required by Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states:

(2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c of this subsection (4).

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

(5)(a) A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of
subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.

(b) A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ten percent of the total amount ultimately allowed on the claim. Such penalty shall be due on the ninety-first day after receipt of the claim by the carrier.

(6) This section shall not prohibit a carrier from retroactively adjusting payment of a claim that is not subject to the provisions of section 10-16-704, if:

(a) The policyholder notifies the carrier of a change in eligibility of an individual; and

(b) The adjustment is made within thirty days after the carrier's receipt of such notification.

Paid and Denied Claims Received Electronically in 2003 Exceeding 30 Days

Data provided by the Company indicated a population of 89,342 paid and denied individual claims received electronically in 2003. The examiners identified 6,451 claims from this population as taking over thirty (30) days from date of receipt to process. A randomly selected sample of one hundred claim files was taken from these 6,451. One hundred of these claims do not appear to have been processed as required by Colorado insurance law with respect to the allowed time frame.

PAID AND DENIED ELECTRONIC CLAIMS OVER 30 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
6,451	100	100	100%

(<1% of all paid and denied electronic claims)

Paid and Denied Claims Received Non-Electronically in 2003 Exceeding 45 Days

Data provided by the Company indicated a population of 56,559 paid and denied individual claims received non-electronically in 2003. The examiners identified 4,389 claims from this population as taking over forty-five (45) days from date of receipt to process. A randomly selected sample of fifty (50) claim files was taken from these 4,389 files. Fifty (50) of these claims do not appear to have been processed as required by Colorado insurance law with respect to the allowed time frame.

PAID AND DENIED NON-ELECTRONIC CLAIMS OVER 45 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
4,389	50	50	100%

(<1% of all paid and denied non-electronic claims)

Paid and Denied Claims Received in 2003 Exceeding 90 Days

Data provided by the Company indicated 146,555 paid and denied individual claims received in 2003. The original data provided by the Company reflected a "U" (unknown) in the type of submission for seven hundred sixty-one (761) of these claims. One hundred thirteen (113) of these seven hundred sixty-one (761) claims had Paid Days exceeding thirty (30) days and were included in the population after the

Company manually researched each and entered the appropriate identifier as to the type of submission. The population at this point was 145,907 paid and denied claims received in 2003. The examiners identified 4,365 claims from this population of 145,907 as taking over ninety (90) days from date of receipt to process. These claims do not appear to have been paid, denied, or settled as required by Colorado insurance law with respect to the ninety (90) day time period.

CLAIMS NOT PAID, DENIED OR SETTLED WITHIN NINETY (90) DAYS

Population	Sample Size	Number of Exceptions	Percentage to Population
4,365	N/A	4,365	100%

(3% of all paid and denied claims)

Recommendation No. 33:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that all claims are paid, denied, or settled within the appropriate time periods as required by Colorado insurance law.

Issue J2: Failure, in some cases, to accurately process claims.

Section 10-3-1104(1), C.R.S., Unfair methods of competition and unfair or deceptive acts or practices

(f) Unfair discrimination states:

(II) Making or permitting any unfair discrimination between individuals of the same class or between neighborhoods within a municipality and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever;

(h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part II or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:

(VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear; …

Randomly selected samples were chosen for review of processing from the population of individual paid and denied claims received from January 1, 2003 through December 31, 2003. Four (4) claims from the paid claims sample and twenty-three (23) claims from the denied claims sample do not appear to have been processed correctly:

INDIVIDUAL PAID CLAIMS

Population	Sample Size	Number of Exceptions	Percentage to Sample
119,056	100	4	4%

INDIVIDUAL DENIED CLAIMS

Population	Sample Size	Number of Exceptions	Percentage to Sample
27,499	100	23	23%

Recommendation No. 34:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-3-1104 C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established the necessary procedures to ensure that claim procedures are reviewed for accuracy of payment that is in compliance with Colorado insurance law. Additionally, it is recommended that the Company conduct a self-audit of all claims involving the denial of the professional component of lab services performed in network facilities and report its results to the Market Conduct Section of the Colorado Division of Insurance.

Issue J3: Failure to accurately determine the number of days utilized for claim processing.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states:

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

(5)(a) A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.

(b) A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ten percent of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.

Section 10-16-121, C.R.S., Required contract provisions in contracts between carriers and providers, states:

(1) A contract between a carrier and a provider or its representative concerning the delivery, provision, payment, or offering of care or services covered by a managed care plan shall make provisions for the following requirements:

(c) Any contract providing for the performance of claims processing functions by an entity with which the carrier contracts shall require such entity to comply with section 10-16-

106.5 (3), (4), and (5).

The Company has contracted with two PPO Networks in Colorado; PHCS and Sloans Lake. For PHCS policyholders, claims come directly to the company to be processed. Providers who belong to the Sloans Lake Managed Care network receive a Provider Services Manual which directs them to submit claims to Sloans Lake for repricing rather than initially submitting them to Fortis.

The data being entered into the Company's claim system and used for computing the days from initial receipt of a claim until the check/explanation of benefits is mailed to the claimant (processing time) appears to be producing an incorrect number of days as indicated by the following procedures:

- The paid date being entered in the Company's system and used to compute the processing time for claims is the date the claim adjudication is completed by the claims examiner. The EOB's and checks are printed and mailed the day after adjudication and if adjudicated on a Friday are printed and mailed on the following Monday.

- The received date being entered in the Company's system and used to compute the processing time for claimants belonging to the Sloans Lake Managed Care network, is the date the repriced claim is received from Sloans Lake, rather than the date of receipt by Fortis.

These procedures create additional calendar days beyond what is entered in the Company's system as processing time and results in an inability to accurately track the number of days utilized for processing of claims and to determine in all instances those for which late payment interest and penalties would apply. Carriers cannot avoid their statutory obligations regarding the amount of time allowed for processing claims without interest/penalty being due because an intermediary repricer is involved.

Recommendation No. 35:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-16-106.5 and 10-16-121, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established the necessary procedures to ensure compliance with Colorado insurance law in accurately determining the number of days used to process claims.

Issue J4: Failure, in some instances, to pay late payment interest/penalties on claims.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states:

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary o resolve the claim, the claim shall be paid, denied, or settled y the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

(5)(a) A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.

(b) A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ten percent of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.

The Company's computation and payment of late payment interest/penalties is not system generated, but requires manual intervention and the amounts are paid concurrently with the claim. The Company's responses to Comment Forms J2, J2-First Addendum and J2-Second Addendum, issued for failure to pay, settle or deny within the time periods required by Colorado insurance law, indicated that late interest and penalties were not paid in all applicable instances.

ELECTRONICALLY RECEIVED CLAIMS-LATE PAYMENT INTEREST/PENALTIES DUE & NOT PAID

Population	Sample Size	Number of Exceptions	Percentage to Sample
6,451	100	100	100%

NON-ELECTRONICALLY RECEIVED CLAIMS-LATE PAYMENT INTEREST/PENALTIES DUE & NOT PAID

Population	Sample Size	Number of Exceptions	Percentage to Sample
4,389	50	50	100%

CLAIMS EXCEEDING NINETY DAYS-LATE PAYMENT INTEREST/PENALTIES DUE & NOT PAID

Population	Sample Size	Number of Exceptions	Percentage to Sample
4,365	N/A	4,365	100%

Recommendation No. 36:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that late payment interest and penalties are paid in all applicable instances as required by Colorado insurance law. Additionally, it is recommended that the Company conduct a self-audit to determine if late interest and penalty payments on claims are paid in all applicable instances and that it report its results to the Market Conduct Section of the Colorado Division of Insurance.

UTILIZATION REVIEW FINDINGS

Issue K1: Failure to reflect complete utilization review guidelines in an operational policy and procedures document.

Amended Regulation 4-2-17, Prompt Investigation Of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(3)(b) and 10-16-109, Colorado Revised Statutes (C.R.S.), states:

Section 4. Definitions

(O) "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review. For the purposes of this regulation, utilization review shall also include reviews for the purpose of determining coverage based on whether or not a *procedure or treatment is considered experimental or investigational* in a given circumstance, and reviews of a covered person's medical circumstances when necessary to *determine if an exclusion applies* in a given situation. [Emphases added.]

Section 5. Compliance Requirements

(A) A health carrier that does not use a procedure for investigating claims involving utilization review that is consistent with this regulation shall be deemed not to be in compliance with the requirement under the unfair competition and deceptive practice insurance statutes of Colorado that a carrier refrain from denying a claim without conducting a reasonable investigation based upon all available information. (Section 10-3-1104(I)(h)(IV), C.R.S.)

(B) A health carrier that uses standards in the review of claims involving utilization review that are not in compliance with the rules contained in this regulation shall be deemed not to be in compliance with the requirement under the unfair competition and deceptive practice insurance statutes of Colorado that a carrier use reasonable standards for the prompt investigation of claims. (Section 10-3-1104(I)(h)(III), C.R.S.)

Section 6. Procedures For Review Decisions

(C)(3) In the case of an adverse determination, the carrier shall notify by telephone the provider rendering the service within one (1) working day of making the adverse determination; and shall provide written or electronic confirmation to the covered person and the provider

within one (1) working day of the telephone notification. The service *shall be continued without liability to the covered person until the covered person and the provider rendering the service have been notified of the determination*. [Emphasis added.]

Section 8. Appeals of Adverse Determinations

I. Standard Appeals

(A)(3) For standard appeals the health carrier shall notify in writing both the covered person and the attending or ordering provider of the decision within twenty (20) working days following the request for an appeal. *The written decision shall contain*: [Emphasis added.]

(d) A reference to the evidence or documentation used as the basis for the decision, including the clinical review criteria used to make the determination, *and instructions for requesting the clinical review criteria;* [Emphasis added.]

II. Expedited Appeals

(E) A health carrier shall provide written confirmation of its decision concerning an expedited review within two (2) working days of providing notification of that decision, if the initial notification was not in writing. In the case of an adverse determination, the *written decision shall contain the provisions specified in Section 8.I.A.3 (a) through (e) of this regulation*. [Emphasis added.]

In the following instances, the Company's Health Management Operational Policy and Procedure document, does not reflect standards of practice to be followed while performing prospective, concurrent and retrospective reviews, that are in compliance with Colorado insurance law.

Utilization Management procedures are incomplete in that the description does not include reviews for determining coverage based on experimental or investigational purposes or reviews to determine if an exclusion applies.

Information for notification of adverse determinations for concurrent reviews does not reflect the provision that services are to be continued without liability to the covered person until the required notification has been provided to both the Insured and the provider rendering the service.

The procedure for written notification of continued non-certifications for expedited appeal requests does not reflect the following required element. There is no mention that the notification must include the instructions for the covered person to request the clinical review criteria.

Recommendation No. 37:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that, as required by Colorado insurance law, complete information is reflected for utilization review guidelines in its Policy and Procedures document.

Issue K2: Failure to provide correct or complete information related to an insured's right to appeal adverse determinations.

Amended Regulation 4-2-17, Prompt Investigation Of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(3)(b) and 10-16-109, Colorado Revised Statutes (C.R.S.), states:

Section 8. Appeals of Adverse Determinations

For purposes of this section, "covered person" includes the designated representative of a covered person.

I. Standard Appeals

A health carrier shall establish written procedures for the review of an adverse determination involving a situation where the time frame of the review would not jeopardize either the life or health of the covered person or the covered person's ability to regain maximum function. For the purposes of this regulation, this process shall be called a "standard appeal." A standard appeal shall be available to, and may be initiated by, the covered person or the representative of a covered person.

A. First Level Appeal Review

3. For standard appeals the health carrier shall notify in writing both the covered person and the attending or ordering provider of the decision within twenty (20) working days following the request for an appeal. …

B. Second Level Appeal Review

3. A health carrier's procedures for conducting a second level panel review shall include the following:

a) The review panel shall schedule and hold a review meeting *within forty-five (45) working days of receiving a request* from a covered person for a second level review. [Emphasis added.] Whenever a covered person has requested the opportunity to appear in person before authorized representatives of the health carrier, the review meeting shall be held during regular business hours at a location reasonably accessible to the covered person, *including accommodation for disabilities.* [Emphasis added.] Carriers shall in no way discourage a covered person from requesting a face-to-face review meeting. In cases where a face-to-face meeting is not practical for geographic reasons, a health carrier shall offer the covered person the opportunity to communicate with the review panel, at the health carrier's expense, by conference call, video conferencing, or other appropriate technology. The covered person

shall be notified *in writing* at least fifteen (15) working days in advance of the review date. [Emphasis added.] The health carrier shall not unreasonably deny a request for postponement of the review made by a covered person.

d) The notice shall advise the covered person of the rights specified in this section 8.I.B;

e) If the health carrier desires to have an attorney present to represent the interests of the health carrier, it shall notify the covered person at least fifteen (15) working days in advance of the review that an attorney will be present and that the covered person may wish to obtain legal representation of his or her own. Within five (5) working days in advance of the review, the covered person shall inform the carrier if the covered person intends to have an attorney present to represent such person's interests.

g) The review panel, after private deliberation, *shall issue a written decision to the covered person within five (5) working days* of completing the review meeting. …[Emphasis added.]

Amended Regulation: 4-2-21, External Review of Benefit Denials of Health Coverage Plans, promulgated and adopted by the commissioner of Insurance under the authority of § 10-1-109, 10-16-109, 10-16-113(3)(b) and 10-16-113.5(4)(d), C.R.S., states:

Section 5. Notice and Disclosure of Right to External Review

A. (1) A carrier shall notify the covered person in writing of the covered person's right to request an external review *and include the appropriate statements and information set forth in (2) of this Subsection A at the time the carrier sends written notice of carrier's final adverse determination.* [Emphasis added.]

(2) The carrier shall include in the required notice a copy of the description of both the standard and expedited external review procedures the carrier is required to provide pursuant to Subsection B, *including the provisions in the external review procedures that give the covered person or the covered person's designated representative the opportunity to submit new information* and including any forms used to process an external review, as specified by the Division of Insurance. [Emphasis added.]

Section 8. Standard External Review

A. (1) Except as provided in Paragraph (2) of this Subsection A, the carrier, upon receipt of a complete request for an external review pursuant to Section 6 of this regulation, shall deliver a copy of the request to the commissioner within two (2) working days.

(2) If the carrier, before the expiration of the deadline for sending notification to the commissioner, reverses its final adverse determination based on new information submitted by the covered person or the designated representative pursuant to Section 6, Subsection E, *the carrier must notify the covered person or the designated representative within one working day of its reversal, electronically, by facsimile, or by telephone, followed by a written confirmation.*

B. (3) Within two (2) working days of receipt of notice from the carrier, the covered person or the designated representative may provide the commissioner with documentation regarding a potential conflict of interest of the independent external review entity, electronically, by facsimile, or by telephone, followed by a written confirmation. If the commissioner determines that the independent external review entity presents a conflict of interest as described in § 10-16-113.5(4)(b), C.R.S., the commissioner shall assign, within one (1) working day, another independent external review entity to conduct the external review that has been approved pursuant to Section 11 of this regulation. Upon this reassignment, the commissioner shall notify the carrier, electronically, by facsimile, or by telephone, followed by a written confirmation, of the name and address of the new independent external review entity to which the appeal should be sent. The commissioner will notify the covered person or the designated representative in writing of the commissioner's determination regarding the potential conflict of interest and the name and address of the new independent external review entity, if applicable.

C. (1) Within six (6) working days from the date the carrier receives notice from the commissioner pursuant to paragraph (1) of Section 8B, the carrier shall deliver to the assigned independent external review entity the following documents and information considered in making the carrier's final adverse determination including:

(a) any and all information submitted to the carrier by a health care professional or the covered person or designated representative in support of the request for coverage under the health coverage plan's procedures;

(b) any and all information used by the plan during the internal appeal process to determine the medical necessity, medical appropriateness, medical effectiveness, or medical efficiency of the proposed treatment or service, including medical and scientific evidence and clinical review criteria;

(c) a copy of any and all denial letters issued by the plan concerning the case under review;

(d) a copy of the signed consent form, authorizing the carrier to disclose protected health information, including medical records, concerning the

covered person that is pertinent to the external review; and

(e) an index of all submitted documents.

(2) Within two (2) working days of receipt of the material specified in Paragraph (1) of this Subsection C, the independent external review entity shall deliver to the covered person or the designated representative the index of all materials that the plan has submitted to the independent external review entity. The carrier shall provide to the covered person or designated representative, upon request, all relevant information supplied to the independent external review entity that is not confidential or privileged under state or federal law concerning the case under review.

(3)(a) The certified independent external review entity shall notify the covered person or the designated representative, the health care professional of the covered person, and the carrier of any additional medical information required to conduct the review after receipt of the documentation required pursuant to Paragraph (1) of this Subsection C. *Within five (5) working days of such a request, the covered person or the designated representative or the health care professional of the covered person shall submit the additional information, or an explanation of why the additional information is not being submitted to the certified independent external review entity and the carrier.*

H.(1) Except as provided in Paragraph (2) of this Subsection H, within thirty (30) working days after the date of receipt of the request for external review by the carrier, the assigned independent external review entity shall provide *written notice* of its decision to uphold or reverse the carrier's final adverse determination to: [Emphasis added.]

(a) The covered person;

(b) If applicable, the covered person's designated representative;

(c) The carrier;

(d) The physician or other health care professional of the covered person; and

(e) The commissioner. [Emphases added.]

(4) Upon carrier's receipt of the independent external review entity's notice of a decision pursuant to Paragraph (1) of this Subsection H reversing the carrier's final adverse determination, the carrier shall approve the coverage that was the subject of the carrier's final adverse determination. For concurrent and prospective reviews, the carrier shall approve the coverage within one (1) working day. For retrospective reviews, the carrier shall approve the coverage within five (5) working days. The carrier shall provide written notice of the approval to the covered person or the designated representative within one (1)

working day of the carrier's approval of coverage. The coverage shall be provided subject to the terms and conditions applicable to benefits under the health coverage plan.

Section 9. Expedited External Review

A. (1) Except as provided in Subsection I of this section 9, a covered person or the covered person's designated representative may make a request for an expedited external review with the carrier if the covered person has a medical condition where the timeframe for completion of a standard external review pursuant to Section 8 of this regulation would seriously jeopardize the life or health of the covered person, *would jeopardize the covered person's ability to regain maximum function or, for persons with a disability, create an imminent and substantial limitation of their existing ability to live independently.* [Emphasis added.]

B. (2) Within one (1) working day of notice from the commissioner pursuant to Paragraph (1) of this Subsection B, the carrier shall notify the covered person or designated representative, electronically, by facsimile, or by telephone followed by a written confirmation. The notice shall include a written description of the independent external review entity that the commissioner has selected to conduct the independent review.

D. (1) Within three (3) working days of the time the carrier receives the request pursuant to Subsection A, the carrier shall provide or transmit all necessary documents and information, as described in Section 8C (1), considered in making the carrier's final adverse determination to the assigned independent external review entity electronically or by telephone or facsimile or any other available expeditious method.

E. The certified independent external review entity shall notify, electronically, by facsimile, or by telephone followed by a written confirmation, the covered person or designated representative, the health care professional of the covered person, and the carrier of any additional medical information required to conduct the review after receipt of the documentation required pursuant to subsection D of this Section 9. *The covered person or designated representative or the health care professional of the covered person shall submit the additional information, or an explanation of why*

the additional information is not being submitted to the certified independent external review entity and the carrier within two (2) working days of such a request. [Emphasis added.]

H. (4) Upon carrier's receipt of the independent external review entity's notice of a decision pursuant to Paragraph (1) of this Subsection H reversing the carrier's final adverse determination, the carrier shall approve the coverage that was the subject of the carrier's final adverse determination within one (1) working day. The carrier shall provide written notice of the approval to the covered person or the designated representative within one (1) working day of receipt of the notice pursuant to Paragraph (1) of this Subsection H. The coverage shall be provided subject to the terms and conditions applicable to benefits under the health coverage plan.

I. An expedited external review may not be provided for retrospective adverse determinations.

The Company's two (2) pages titled "Insured's Right To Appeal" that is included with notice of an adverse determination and describes the appeal procedures available to an insured, does not appear to be in compliance with Colorado insurance law in the following ways:

First Level Appeal Reviews

1. The time period for notification of a decision shall be within twenty (20) working days following the request for an appeal, not within twenty (20) working days of receipt of all information required for the review.

Second Level Appeal Reviews

1. There is no limitation of sixty (60) business days after receipt of a notice of an adverse determination for a covered person to file a request for a Second Level Appeal Review.

2. There is no notification provided to covered persons requesting the opportunity to appear in person before authorized representatives of the health carrier that if needed, accommodations for disabilities are to be provided.

3. Nothing is reflected to indicate that the health carrier will notify the covered person at least fifteen (15) working days in advance of the review if they plan to have an attorney present at second level panel reviews. Additionally there is nothing advising the covered person that they may wish to obtain legal representation and should inform the carrier five (5) working days in advance of the review if he or she intends to have an attorney present.

4. Nothing is reflected to indicate that the fifteen (15) working days in advance notification of the

review date is to be in writing.

5. A review panel shall schedule and hold a review meeting within forty-five (45) business days of receiving a request from a covered person, not within forty-five (45) business days of receipt of all information required for the review.

6. Nothing is reflected concerning the requirement of the review panel to issue a written decision within five (5) working days of completing the review meeting.

Standard External Review

1. Nothing is reflected to indicate to the covered person or the covered person's representative that they have the right to submit new information.

2. There is no information being relayed to the covered person concerning the notification requirements of the carrier if, based on new information submitted by the covered person or his/her representative, the carrier reverses its final adverse determination before the deadline for sending notification of the request for an External Review to the Commissioner.

3. Nothing is reflected concerning the covered person's, or the designated representative's, right to provide documentation regarding a potential conflict of interest with the independent external review entity and the procedure that is to follow should this be determined to be true.

4. Nothing is reflected concerning the requirement of the carrier to provide to the covered person or designated representative, upon request, all relevant information supplied to the independent external review entity that is not confidential or privileged under state or federal law concerning the case under review.

5. Nothing is reflected concerning the fact that if additional medical information is requested by the independent external review entity that the covered person, the designated representative or health care professional of the covered person has five (5) working days of such a request to respond.

6. The statement indicating who will receive notice of the independent external review entity's decision is not complete as it does not reflect (1) If applicable, the covered person's designated representative or (2) The commissioner, and (3) does not reflect that it will be written notice.

7. There is no disclosure reflected concerning the time periods within which the carrier is required to approve coverage for concurrent, prospective and retrospective reviews and to provide written notice of the approval to the covered person or designated representative once the independent external review entity's decision is received.

Expedited External Review

1. Two (2) of the medical conditions for allowing a request to be made for an expedited external review are not reflected; (1) It would jeopardize the covered person's ability to regain maximum

function or (2) It would create an imminent and substantial limitation of their existing ability to live independently.

2. Nothing is reflected concerning the carrier's responsibility to notify the covered person or designated representative, electronically, by facsimile, or by telephone, of the independent external review entity that has been selected to conduct the independent review nor that this notification is to be provided within one (1) working day of notice from the commissioner and followed by a written confirmation.

3. Nothing is reflected concerning the carrier's responsibility to provide or transmit all necessary documents and information considered in making the carrier's final adverse determination to the independent external review entity within three (3) working days of the request for an expedited external review.

4. Nothing is reflected concerning the two (2) working days allowed for the covered person or designated representative, or the health care professional of the covered person to submit any additional medical information required to conduct the review, or an explanation of why the additional information is not being submitted, when requested by the independent external review entity.

5. Nothing is reflected concerning the time period (1 working day) within which the carrier is required to approve coverage and provide written notice of the approval in the case of the external review entity's notice of a decision reversing the carrier's final adverse determination.

6. Nothing is reflected to indicate that an expedited external review may not be provided for retrospective adverse determinations.

The wording on page 1 of the "Insured's Right To Appeal" pages is:

Fortis Health

Insured's Right To Appeal (Colorado)

You have the right to appeal the adverse decision or you may designate a representative to appeal for you. The following information describes the appeal procedure.

Level I Appeal Request:

You or your designated representative may request a Level I Appeal of an adverse decision within one hundred and eighty days (180) business days from the date of the attached letter.

- Include in your request any additional medical information that you feel is pertinent to you case.
- We will send you written acknowledgement of your request.
- The Level I Appeal review will be completed and written notification of the decision will be sent to you within twenty (20) business days of receipt of all information required for the review.

- Send the request either in writing or by telephone or fax to:

Fortis Health
Health Management – Appeals Department
PO Box 3264
Milwaukee, WI. 53201-3264

Telephone 1-800-454-5105, ext. 6239
Fax: 1-414-299-7555 Attn: Health Management Appeals Department

Level II Appeal Request:

If you wish to appeal the Level I Appeal decision, you or your designated representative may request a Level II Appeal Panel review. This request must be received in writing at the above address within sixty (60) business days of the date of the Level I Appeal decision letter.

- Include in your request any additional medical information that you feel is pertinent to your case.
- We will send you written acknowledgement of your request.
- The Level II Appeal Panel review will be completed within forty-five (45) business days of receipt of all information required for the review. We will notify you of the decision.
- You have the right to attend the Level II Appeal Panel review. You will be informed of the date and time at least fifteen (15) days in advance of the meeting. If you are unable to attend, we will set up a conference call at your request.

The wording on page 2 of the "Insured's Right To Appeal" pages is:

- Our internal appeals process will be exhausted upon completion of the Level II Appeal Panel decision.

Independent External Review Requests:

If you are dissatisfied with the Level II Appeal Panel decision, you have the right to file a request for an Independent External Review after all internal appeals processes have been exhausted.

If you wish to have an Independent External Review you will need to complete the attached request form and submit to us within sixty (60) calendar days of receipt of the upheld Level II Appeal letter to the above listed address.

You will need to include the following with the request:

- A completed request form (enclosed), for an Independent External Review;
- A copy of the upheld Level II Appeal letter; and
- A signed release of information form allowing the Independent External Review Entity to obtain medical information from relevant providers and us.

We will notify you in writing of the certified Independent External Review Entity that the Department (or its contractor) has selected to conduct the external review upon receipt of the written request for external review.

You may contact us at the above address and phone number if you have any questions.

You may request an expedited Independent External review in writing if your physician certifies that you have a medical condition that would seriously jeopardize your life or health if standard timeframes were followed. The expedited review will be completed y the Independent External Review Entity within seven (7) business days of receipt of the request. This Independent External Review Entity may request an extension for up to five (5) business days for the consideration of additional information.

We will provide you with all relevant information submitted to the Independent External Review Entity that is NOT confidential or privileged upon your request.

We will notify you and the Independent External Review Entity in writing if we determine that additional information provided by you or your health care professional justifies a reconsideration of the adverse decision. The Independent External Review will then be terminated.

The certified Independent External Review Entity will submit its decision to you, your physician and us within thirty (30) business days of our receipt of the request. The Independent External Review Entity may request an extension for up to ten (10) business days for the consideration of additional information. The decision of the Independent External Review Entity will be binding.

Form No.	Form Name
None (2 pages with date of 3-14-01)	Insured's Right To Appeal (Colorado)

Recommendation No. 38:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulations 4-2-17 and 4-2-21. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that, as required by Colorado insurance law, correct and complete descriptions of appeal procedures available to an insured are included with notice of adverse determinations.

Issue K3: Failure to include all required elements in written notification letters for First Level Appeal Reviews.

Amended Regulation 4-2-17, Prompt Investigation Of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(3)(b) and 10-16-109, Colorado Revised Statutes (C.R.S.), states:

> Section 8. Appeals of Adverse Determinations
>
> A. First Level Appeal Review
>
> 3. For standard appeals the health carrier shall notify in writing both the covered person and the attending or ordering provider of the decision within twenty (20) working days following the request for an appeal. *The written decision shall contain:*
>
> (a) The *name, title* and qualifying credentials of the physician evaluating the appeal, and the qualifying credentials of the clinical peer(s) with whom the physician consults. (For the purposes of this section, the physician and consulting clinical peers shall be called "the reviewers"); [Emphasis added.]

The written notification letter used by the Company for First Level Appeal Reviews and sent to the covered person and provider does not appear to be in compliance with Colorado insurance law as the following required elements are not included in the notification letter:

1. The name and title of the physician involved in the review is not reflected.

Recommendation No. 39:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that notification letters used for First Level Appeal Reviews include all required elements in compliance with Colorado insurance law.

Issue K4: Failure to enter written First Level or any Second Level Review Appeals into the complaint record.

Amended Regulation 4-2-17, Prompt Investigation of Health Plan Clams Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(3)(b) and 10-16-109, Colorado Revised Statutes (C.R.S.), states:

> Section 8. Appeals of Adverse Determinations
>
> A. First Level Appeal Review
>
> 1. … Pursuant to Section 10-3-1104(1)(i), C.R.S., *all written requests for a standard first level appeal review must be entered into the carrier's complaint record*. …[Emphasis added]
>
> B. Second Level Appeal Review
>
> 4. *A complaint record entry shall be made for all second level appeals*, pursuant to Section 10-3-1104(1)(i), C.R.S., and insurance Regulation 6-2-1. [Emphasis added.]

The Company provided data indicating that there were thirty-three (33) First Level Review Appeals and thirteen (13) Second Level Review Appeals received in 2003, the year under examination. From a review of the files, it appears that all thirty-three First Level Review Appeals were written. None of the First Level or the Second Level Review Appeals was entered into the carrier's complaint records as required by Colorado insurance law.

Recommendation No. 40:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that all written First Level and all Second Level Review appeals are entered into the Company's complaint record in compliance with Colorado insurance law.

Issue K5: Failure to use correct procedures in conducting Utilization Review.

Amended Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(3)(b) and 10-16-109, Colorado Revised Statute (C.R.S.) states:

Section 6. Procedures For Review Decisions

D. For retrospective review determinations, a health carrier *shall make the determination within thirty (30) working days of receiving all necessary information*. In the case where a determination cannot be made because the carrier does not receive all information necessary to make the decision with the original request for treatment, *the carrier shall request in writing, within two (2) working days, the additional information needed.* The carrier shall allow twenty (20) calendar days to receive the requested information. *Within thirty (30) working days of the due date or receipt date, whichever is earlier, the carrier shall make a determination* based on the available information and provide notification as specified in paragraphs (1) and (2) below. [Emphases added.]

1) In the case of a certification, the carrier shall notify in writing the covered person and the provider rendering the service *within five (5) working days of making the determination* to provide coverage. [Emphasis added.]

2) In the case of an adverse determination, the carrier shall notify in writing the provider rendering the service and the covered person *within five (5) working days of making the adverse determination*. [Emphasis added.]

Section 8. Appeals of Adverse Determinations

A. First Level Appeal Review

2. Appeals shall be evaluated by a physician *who shall consult with an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed.* [Emphasis added.] The physician and clinical peer(s) shall not have been involved in the initial adverse determination. However, a person that was previously involved with the denial may answer questions.

B. Second Level Appeal Review

1. With respect to a second level appeal review of a grievance concerning an adverse determination, a health carrier shall appoint a second level grievance review panel for each grievance. The panel shall include a minimum of three (3) people. The panel may be composed of employees of the health coverage plan who have appropriate professional expertise. A majority of the panel shall be

comprised of persons who were not previously involved in the grievance. However, a person who was previously involved with the grievance may be a member of the panel or appear before the panel to present information or answer questions.

2. A health carrier shall ensure that a majority of the persons reviewing a grievance involving an adverse determination are health care professionals who have appropriate expertise. Such reviewing health care professionals shall meet the following criteria: not have been involved in the care previously; not be a member of the board of directors of the health plan; not have been involved in the review process for the covered person previously; and not have a direct financial interest in the case or in the outcome of the review. A health carrier shall issue a copy of the written decision to the covered person and to a provider who submits a grievance on behalf of a covered person.

3. A health carrier's procedures for conducting a second level panel review shall include the following:

   a) The review panel shall schedule and hold a review meeting within forty-five (45) working days of receiving a request from a covered person for a second level review. Whenever a covered person has requested the opportunity to appear in person before authorized representatives of the health carrier, the review meeting shall be held during regular business hours at a location reasonably accessible to the covered person, including accommodation for disabilities. Carriers shall in no way discourage a covered person from requesting a face-to-face review meeting. In cases where a face-to-face meeting is not practical for geographic reasons, a health carrier shall offer the covered person the opportunity to communicate with the review panel, at the health carrier's expense, by conference call, video conferencing, or other appropriate technology. The covered person shall be notified in writing at least fifteen (15) working days in advance of the review date. The health carrier shall not unreasonably deny a request for postponement of the review made by a covered person.

   b) Upon the request of a covered person, a health carrier shall provide to the covered person all relevant information that is not confidential or privileged under state or federal law.

   c) A covered person has the right to:

      (1) Attend the second level review;

(2) Present his or her case to the review panel in person or in writing;

(3) Submit supporting material both before and at the review meeting;

(4) Ask questions of any representative of the health carrier prior to the hearing and question any panelist at the hearing; and

(5) Be assisted or represented by a person of his or her choice.

d) The notice shall advise the covered person of the rights specified in this section 8.I.B;

e) If the health carrier desires to have an attorney present to represent the interests of the health carrier, it shall notify the covered person at least fifteen (15) working days in advance of the review that an attorney will be present and that the covered person may wish to obtain legal representation of his or her own. Within five (5) working days in advance of the review, the covered person shall inform the carrier if the covered person intends to have an attorney present to represent such person's interests.

f) The covered person's right to a fair review shall not be made conditional on the covered person's appearance at the review.

g) The review panel, after private deliberation, shall issue a written decision to the covered person within five (5) working days of completing the review meeting. The decision shall include:

1) The names, titles, and qualifying credentials of the members of the review panel;

2) A statement of the review panel's understanding of the nature of the grievance and all pertinent facts;

3) The rationale for the review panel's decision;

4) Reference to evidence or documentation considered by the review panel in making that decision;

5) In cases involving an adverse determination, the instructions

for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination, and additional appeal, review, arbitration or other options available to the covered person, if any; and

6) Effective June 1, 2000, notice of the covered person's right to request an independent external review. The notice shall comply with Section 5 of insurance Regulation 4-2-21.

A population of 759 cases involving utilization review in 2003 was provided by the Company and a sample of fifty (50) files was selected for review. The data provided by the Company indicated thirteen (13) Second Level Appeals and thirty-three (33) First Level Appeals and these populations were used as the sample. The processing of these utilization review cases did not appear to be correct in the following instances:

First Level Appeal Cases

There were two (2) cases in which it appeared that there was incorrect processing of First Level Appeal Reviews.

1. In one case an unnecessary First Level Appeal was processed after denial of benefits as not medically necessary. The outpatient rehabilitation benefit of $3,000 had already been provided prior to the date of service and the fact that there was no available benefit for the services being appealed would have been available in the Company's claim system at the time of receipt of the claim initiating utilization review thereby negating the necessity of a First Level Appeal.

2. A second case involved neurologically based services, was reviewed by a doctor Board Certified in Internal Medicine and denied. The insured questioned this, but there is no documentation that the question was ever answered. Colorado insurance law requires that a Level I Appeal Review is to be evaluated by a physician who shall consult with an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The Company indicated that no other physician was involved in the Level I Appeal Review denying the claim.

Second Level Appeal Cases

There were eleven (11) cases in which it appeared that there was incorrect processing of Second Level Appeal Reviews.

There were eleven (11) instances in which the Company's letter to the insured notifying of the proposed date for an appearance before the review panel, did not include any notification that the carrier would have an attorney present to represent the interests of the health carrier. The Company had advised that a Fortis Health attorney attends the Grievance Panel meetings and serves in an advisory capacity to the Panel. Additionally, this letter did not reflect any notification to the covered person that he/she could obtain legal representation of their own and should inform the carrier five (5) working days in advance of the review if they decided to do so.

Neither does the "Insured's Right To Appeal" information (2 pages) that is provided when a claim is denied, reflect any of this information.

There were five (5) instances in which the written notification of an adverse decision for the Second Level Review Panel did not comply with Colorado insurance law in one or more of the following ways:

- Did not appear to have been provided to the covered as it was addressed to an attorney with a copy to the provider
- Did not include the names, title or qualifying credentials of the review panel

There were four (4) instances in which letters confirming receipt of the request for a Second Level Appeal incorrectly advise the covered person that they may communicate with the review panel at their expense by conference call if they are unable to attend.

There were two (2) instances in which letters confirming receipt of the request for a Second Level Appeal did not comply with Colorado insurance law in the following ways:

- Did not include notification of the time and place the review meeting was to be held so that the covered person could attend or participate should they decide to do so
- Did not include a statement that the covered person could ask questions of any representative of the health carrier prior to the hearing and question any panelist at the hearing

There was one (1) instance in which an incorrect limitation on the time allowed an insured and his Colorado Patient Advocate to present an appeal was reflected in the letter advising of the date for the Level II Appeal of services. The letter reflected: "You and your representative will have not more than 15 minutes to present your appeal in person or by phone."

There was one (1) instance of an unnecessary Second Level Appeal that was processed after denial of benefits as not medically necessary. The outpatient rehabilitation benefit of $3,000 had already been provided prior to the date of service and the fact that there was no available benefit for the services being appealed would have been available in the Company's claim system at the time of receipt of the claim initiating utilization review thereby negating the necessity of a Second Level Appeal.

All Cases of Utilization Review in 2003

There were four (4) cases in which it appeared that there was incorrect processing of Utilization Review.

There were two (2) instances in which the time period between receipt of the additional information needed to conduct retrospective review, make a determination to either certify or deny and the Company's notification to the insured and the provider exceeded the thirty (30) and five (5) working days allowed by Colorado insurance law. Additionally, in one (1) of these cases, the needed information was not requested within the required two (2) working days.

There was one (1) instance in which the time period between receipt of the request for a retrospective review determination (no additional information requested) and notification of the determination to the covered person and the provider exceeded the thirty (30) working days allowed by Colorado insurance law.

There was one (1) instance in which an investigation was conducted to determine if the services provided were for a pre-existing condition. The Company decided the services were not for a pre-existing condition and notified the insured that the expense had been forwarded for reprocessing. The Company was asked for a copy of the explanation of benefits that was issued after the claim was reprocessed and it was discovered that the claim was never adjusted. The claim was reprocessed on December 17, 2004 with $39.00 being applied to the insured's deductible.

FIRST LEVEL APPEAL REVIEWS

Population	Sample Size	Number of Exceptions	Percentage to Sample
33	33	2	6%

SECOND LEVEL APPEAL REVIEWS

Population	Sample Size	Number of Exceptions	Percentage to Sample
13	13	11	85%

ALL CASES OF UTILIZATION REVIEW IN 2003

Population	Sample Size	Number of Exceptions	Percentage to Sample
795	50	4	8%

Recommendation No. 41:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that all utilization review cases are processed as required by Colorado insurance law.

Issue K6: Failure to provide telephone notification of determinations in all cases.

Amended Regulation 4-2-17, Prompt Investigation of Health Plan Claims involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(3)(b) and 10-16-109, Colorado Revised Statutes (C.R.S.), states:

> Section 6. Procedures For Review Decisions
>
> B. *For prospective review determinations*, a health carrier shall make the determination within two (2) working days of obtaining all necessary information regarding a proposed admission, referral, procedure or service requiring a review determination. …[Emphasis added.]
>
> 1) In the case of a determination to certify an admission, referral, procedure or service, *the carrier shall notify by telephone the provider rendering the service within one working day of making the initial certification*; …[Emphasis added.]
>
> 2) In the case of an adverse determination, *the carrier shall notify by telephone the provider rendering the service within one (1) working day of making the adverse determination*; …[Emphasis added.]

From a review of the fifty (50) cases of all Utilization Review decisions, it does not appear that telephone notification calls were made in all required instances. The five (5) cases identified below were for pre-certification however there is an "N/A" in the column titled "Telephone Date" indicating that no call was placed.

No. on Sample List	UR Type	Approved/Denied
1	Pre-Cert	Denied
3	Pre-Cert	Denied
9	Pre-Cert	Denied
21	Pre-Cert	Approved
25	Pre-Cert	Approved

ALL CASES OF UTILIZATION REVIEW IN 2003

Population	Sample Size	Number of Exceptions	Percentage to Population
795	50	5	10%

Recommendation No. 42:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has corrected its procedures to ensure that all future notifications of determinations are provided as required by Colorado insurance law.

Issue K7: Failure, in some cases, to use the correct method of notification for concurrent and retrospective review determinations.

Section 10-16-113, C.R.S., Procedure for denial of benefits, states:

(1) A health coverage plan shall not make a determination that it will deny a request for reimbursement for or coverage of medical treatment or other benefits for a covered individual on the grounds that such treatment or covered benefit is not medically necessary, appropriate, effective, or efficient unless such denial is made pursuant to this section.

(2) *Following a denial by the health coverage plan, such plan shall notify the covered person in writing.* [Emphasis added.] The content of such notification and the deadlines for making such notification shall be made pursuant to regulations promulgated by the commissioner.

(4) *All written denials shall be signed by a licensed physician familiar with standards of care in Colorado.* [Emphasis added.]

Amended Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(3)(b) and 10-16-109, Colorado Revised Statutes (C.R.S.), states:

Section 6. Procedures For Review Decisions

C. 1) For concurrent review determinations …

2) In the case of a determination to certify an extended stay or additional services, the carrier shall notify by telephone the provider rendering the service within one (1) working day of making the certification; *and shall provide written or electronic confirmation to the covered person and/or the provider* within one (1) working day after the telephone notification. [Emphasis added.]

3) In the case of an adverse determination, the carrier shall notify by telephone the provider rendering the service within one (1) working day of making the adverse determination; *and shall provide written or electronic confirmation to the covered person and the provider* within one (1) working day of the telephone notification. …[Emphasis added.]

D. For retrospective review determinations …

1) In the case of a certification, *the carrier shall notify in writing the covered person and the provider* rendering the service within five

(5) working days of making the determination to provide coverage. [Emphasis added.]

2) In the case of an adverse determination, *the carrier shall notify in writing the provider rendering the service and the covered person* within five (5) working days of making the adverse determination. [Emphasis added.]

E. A written notification of an adverse determination shall include the principal reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, including expedited appeals, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make that determination, to any party who received notice of the adverse determination and who follows the procedures for a request. A carrier shall specify that such an appeal process shall include a two-level internal review, except as provided for in section 8.I.A.5. of this regulation.

Colorado insurance law requires written notification of concurrent and retrospective review determinations to be sent to the covered person and the provider of services with specific information to be included with notification of adverse determinations. Additionally, all written denials of coverage for treatment determined to not be medically necessary, appropriate, effective, or efficient are to be signed by a licensed physician familiar with standards of care in Colorado. The examiners identified twenty (20) cases from the sample of fifty (50) cases of Utilization Review decisions made by the Company in 2003, in which it did not send written notification, but instead used the Explanation of Benefits for this purpose.

ALL UTILIZATION REVIEW DECISIONS

Population	Sample Size	Number of Exceptions	Percentage to Sample
795	50	20	40%

Recommendation No. 43:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-113, C.R.S. and Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that the correct method of notification is used for all concurrent and retrospective review determinations as required by Colorado insurance law.

Issue K8: Failure to have notification of denials of claims for "not medically necessary" signed by a licensed physician.

Section 10-16-113, C.R.S., Procedure for denial of benefits, states:

(1) A health coverage plan shall not make a determination that it will deny a request for reimbursement for or coverage of medical treatment or other benefits for a covered individual on the grounds that such treatment or covered benefit is not medically necessary, appropriate, effective, or efficient unless such denial is made pursuant to this section.

(2) Following a denial by the health coverage plan, such plan shall notify the covered person in writing. The content of such notification and the deadlines for making such notification shall be made pursuant to regulations promulgated by the commissioner.

(4) All written denials shall be signed by a licensed physician familiar with standards of care in Colorado.

The Company provided thirty-three (33), Utilization Review-First Level Appeals. It was noted that in thirty (30) of these files the initial written notification of denial reflected a reason of "not medically necessary", however none were signed by a licensed physician. Additionally, one (1) of the first level appeal written notification letters denying coverage was not signed by a licensed physician.

FIRST LEVEL APPEALS

Population	Sample Size	Number of Exceptions	Percentage to Sample
33	33	30	91%

A sample of fifty (50) files was randomly selected from all decisions involving Utilization Review in 2003. It was noted that in three (3) of these files the initial written notification of denial reflected a reason of "not medically necessary", however none were signed by a licensed physician.

ALL UTILIZATION REVIEW DECISIONS

Population	Sample Size	Number of Exceptions	Percentage to Sample
795	50	3	6%

Recommendation No. 44:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-113, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure all written denials of coverage with a reason of "not medically necessary" are signed by a licensed physician as required by Colorado insurance law.

SUMMARY OF ISSUES AND RECOMMENDATIONS

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